IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *ET AL.*,

Petitioners,

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *ET AL.*,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Eastern Kentucky Welfare Rights Organization and other organizations and poor individuals petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit entered in this case on October 9, 1974.

OPINIONS BELOW

The opinion of the Court of Appeals (Appendix C, *infra*, pp. 7a-32a) is reported at 506 F.2d 1278. The memorandum opinion of the District Court (Appendix D., *infra*, pp. 33a-

57a) is reported, *sub nom. Eastern Kentucky Welfare Rights Organization, et al., v. Shultz et al.*, at 370 F. Supp. 325. An additional memorandum order (Appendix E, *infra*, pp. 58a-60-a) and the Judgment (Appendix F, *infra*, pp. 61a-63a) are unreported.

JURISDICTION

The judgment of a divided Court of Appeals for the District of Columbia Circuit, reversing the District Court, was entered on October 9, 1974. A timely petition for rehearing was denied, with dissent (Appendix B, *infra*, p. 6a) as was the suggestion for rehearing *en banc*, with three dissents, on December 6, 1974 (Appendix A, *infra*, pp. 1a-5a). On application filed by the Solicitor General, the Chief Justice extended the time for filing a petition for a writ of certiorari to and including March 8, 1975.[1] The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

QUESTIONS PRESENTED

(1) Whether Respondents, the Secretary of the Treasury and the Commissioner of Internal Revenue, in issuing rules which have a substantial impact upon an industry and

[1] Although the panel majority decided the merits of the case in favor of the Federal officials, all three Judges decided certain jurisdictional issues in favor of petitioners, concerning the applicability of the Tax Injunction Act (26 U.S.C. 7421(a)), the exclusionary clause of the Declaratory Judgment Act pertaining to matters involving Federal taxes (28 U.S.C. 2201), and the doctrine of sovereign immunity, finding the restrictions in those provisions and doctrine inapplicable to the instant case. Compare *Green v. Connally*, 330 F.Supp. 1150 (D.D.C., 1970), aff'd *per curiam sub nom. Coit v. Green*, 404 U.S. 997 (1971) and *McGlotten v. Connally*, 338 F.Supp. 448, 456 (D.D.C., 1972) with *Bob Jones University v. Simon*, _____ U.S. _____, 94 S.Ct. 2038, (1974) and *Alexander v. Americans United*, _____ U.S. _____ 94 S.Ct. 2038 (1974).

rights of a large segment of the public, and alter the legal obligations of that industry to that segment of the public, must follow tthe rule-making requirements of the Administrative Procedure Act (5 U.S.C. 553);

(2) Whether Respondents have violated the Internal Revenue Code by the issuance of an *ad hoc* ruling, eliminating the long-standing requirement that non-profit hospitals provide service to the indigent as a condition of obtaining the status and benefits accorded to "charitable" institutions under the Internal Revenue Code (26 U.S.C. 501((c)(3) and 170(a)-(c));

(3) Whether Respondents could issue a ruling which eliminates the obligations of "charitable" tax exempt hospitals to serve the indigent, without consideration of all relevant factors, including its impact upon the ability of millions of poor persons to obtain hospital services, and the policies and views of Congress and the health agency of the United States which continue to require hospitals to serve the indigent.

STATUTES INVOLVED

The relevant portions of the Internal Revenue Code (26 U.S.C. 501(c)(3) and 170(a)-(c)) and the Administrative Procedure Act (5 U.S.C. 553 and 706(2)(A)) appear in pertinent part in Appendix G to this Petition (pp. 64a-66a, *infra*).

STATEMENT

The Internal Revenue Code, since its inception, has provided tax exemption for the income of, and permitted donors to deduct contributions to, certain organizations categorized as "charitable". (See 26 U.S.C. 501(c)(3) and 170(a)-(c)). Although other organizations categorized as "educational" and "religious" have always been accorded the same benefits as "charitable" organizations, and

"scientific" and "literary" organizations subsequently have been granted similar treatment by Congress, nonprofit hospitals and other nonprofit health institutions have never been granted the same independent status under these provisions of the Code but have only qualified for tax benefits if they fit into the "charitable" category.[2]

The long established position of the Federal Courts, Congress, and the Internal Revenue Service has been that, in order to quality as "charitable" organizations under the Code, nonprofit hospitals must provide service to persons unable to pay and may not limit services exclusively to those able to pay. On October 8, 1969, the Commissioner of Internal Revenue issued a published revenue ruling to the effect that nonprofit hospitals would be eligible for charitable status if they are "operated for the care of all those persons in the community able to pay the cost thereof either directly or through third party reimbursement" and "remove(d) . . . the requirements relating to caring for patients without charge or at rates below cost." (Revenue Ruling 69-545, 1969-2 Cum. Bull. 117, see App. H, *infra*, pp. 67a-72a). This reversal of a long-held requirement was issued without notice to the public or any opportunity to the public and/or interested and affected persons to contest the matter. The ruling, on its face, is totally devoid of any consideration of the needs of indigent persons for hospital services or the number of such persons who, by virtue of the ruling, would be stripped of pre-existing rights for services from tax exempt hospitals.

Petitioners are extremely poor people, and organizations representing poor people, with incomes at or below the

[2] On two occasions amendments were proposed in Congress which would have accorded health institutions (in 1924) and hospitals (in 1969) favorable tax status independent of "charitable" services, but on both occasions the attempt failed. For discussion see District Court Memorandum Opinion, 370 F.Supp. 325, at 331-2, *infra*, pp. .

minimal poverty line guidelines and without health insurance or resources to pay for hospital care. (J.A. 9-11, 13-16). The uncontradicted Affidavits in the record below (J.A. 69-108) recount incidents in various locations across the country since 1969 in which they and other indigent persons were denied needed hospital attention because of their inability to pay for services by institutions which refuse to serve persons unable to pay but still retain their status under the Code as "charitable" institutions in accordance with Revenue Ruling 69-545.

After failing to obtain a reconsideration of the issues underlying Revenue Ruling 69-545, in particular the lack of available hospital services for poor people, and being told by representatives of the Internal Revenue Service and the Department of the Treasury that they were addressing themselves to the wrong forum (J.A. 67-68), Petitioners commenced this action in July 1971. They alleged, *inter alia*, that the Commissioner of Internal Revenue and the Secretary of the Treasury had violated the Internal Revenue Code and the Administrative Procedure Act by the issuance of Revenue Ruling 69-545, which eliminated the requirement that nonprofit hospitals provide services to the indigent in order that they may retain their "charitable" status under the Code, and thus deprived them of their pre-existing rights to obtain services from nonprofit hospitals. The District Court held that they had standing to maintain the action and that it had jurisdiction under 28 U.S.C. 1331, 1340, 1361, 2201, and 2202.

On cross-motions for summary judgment, the District Court held that Revenue Ruling 69-545 violated the Internal Revenue Code. In reaching its decision the District Court relied upon the long-standing judicial authority and the legislative history, which established that nonprofit hospitals must provide service to the indigent in order to retain their status as "charitable" institutions under the Code. In view of that holding, the Court did not decide

whether the peremptory issuance of the ruling also violated the Administrative Procedure Act.

A divided panel in the Court of Appeals reversed the District Court. While acknowledging that in the past Congress and federal courts had conditioned a hospital's "charitable" status on the level of free or below cost care that it provided for indigents, the majority concluded that there was no authority for the conclusion that the determination of "charitable" status was always to be so limited. Despite the total lack of any record that IRS considered the impact of the ruling upon poor people needing hospital services, and despite the admission by respondents' counsel in their brief to the Court of Appeals that IRS lacks expertise in the health area (C.A. Brief, p. 72), the panel majority concluded that IRS could have determined that Revenue Ruling 69-545 may be of greater benefit to the poor than the prior position. Relying upon the same authority as did IRS (i.e., Scott on Trusts and the Restatement of Trusts), the panel majority held that Revenue Ruling 69-545 was founded upon a permissible definition of the term "charitable". The majority also accepted the characterization by respondents that the ruling was "interpretative" and therefore not subject to the rule-making requirements of section 553 of the APA nor an "abuse of discretion" under section 706(2)(A) of the APA.

The dissenting judge stated that he would affirm the District Court for the reasons stated in its opinion and would also, alternatively, hold that the issuance of Revenue Ruling 69-545 worked a substantial change in the availability of hospital services to the poor without, admittedly, giving the poor or anyone else notice and an opportunity to comment upon it as required by section 553 of the Administrative Procedure Act. Over three dissents, review *en banc* was denied.

REASONS FOR GRANTING THE WRIT

Summary of Reasons

The Court below has decided federal questions affecting the availability of hospital services for some 20-40 million poor persons.[3] Its ruling that a federal agency can so determine the obligations of an entire industry and the rights of a large segment of the public dependent upon the industry without notice or opportunity for comment is an intolerable expansion of the "interpretative ruling" exception to the Administrative Procedure Act requirements for rule-making proceedings — an expansion inconsistent with rulings of other Circuits and the guidelines established by this Court in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969).

Furthermore, the IRS has upset practices of more than 30 years' standing in this field without so much as considering the policies or views of Congress or the federal agency charged with primary responsibility for health care, the Department of Health, Education and Welfare, which continue to require that hospitals serve the indigent. Compounding the incompleteness of the administrative record, the court interjected its own speculation that the revenue ruling "may be of greater benefit to the poor than its predecessor . . ." (App. C, *infra*, p. 27a). Matters of such public moment must be decided on a clear record developed in appropriate administrative proceedings.[4] The Court below plainly violated, in this regard, the teaching of

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[3] The size of the affected class is described in point 4, *infra*, pp. -.

[4] The only record on this point is the Affidavits filed by Petitioners in District Court showing that many poor persons were denied hospital services by hospitals which denied admission to the indigent after the issuance of Revenue Ruling 69-545.

Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402 (1971).

The ruling below drastically relaxes the standards for qualifications as a "charitable" organization under the Internal Revenue Code of nonprofit hospitals. It conflicts on this point with numerous rulings of other federal courts. In its own right the question of the scope of the "charitable" organization provisions of the Internal Revenue Code is one of broad general importance warranting review by this Court.

Reasons

1. The decision by the panel majority holding that the rule-making requirements of the Administrative Procedure Act (5 U.S.C. 553) do not apply to the revenue ruling in this case conflicts with the standards set forth for the application of the rule-making requirements by the Second Circuit in *Lewis-Mota v. Secretary of Labor*, 469 F.2d 478 (1972) and by the Third Circuit in *Texaco Inc. v. Federal Power Commission*, 412 F.2d 740 (1969) and by other federal courts. These cases establish that the procedure set forth in section 553 must be followed in connection with an agency rule which departs from a long-established and judicially approved position and eliminates the rights of a large segment of the public.

The Administrative Procedure Act (5 U.S.C. 553) requires that an agency which engages in rule-making must do so by a general notice in the Federal Register which includes the terms or substance of the proposed rule or a description of the subjects and issues involved, and that such agency shall give interested persons an opportunity to participate in the rule-making process through submission of written data, views, and arguments. No less than thirty (30) days notice must be given before the rule is effective. The purpose of this requirement is to assure that agencies

consider all relevant facts and the impact upon society in exercising the legislative functions delegated to them by Congress.

There are a number of exceptions to the rule-making requirements; for rules which are "interpretative" rather than "legislative", which constitute a "general statement of policy", which involve agency procedure, or which are so minor in nature that publication for pre-effective date comment is "unnecessary." In determining whether one of these exceptions applies to a particular rule, other federal courts have rejected the label which the agency itself puts on the rule and rather have looked to what the rule in fact has done. These several courts have held that the rule is subject to the requirements of section 553, despite its label, upon an affirmative finding of one or more of the following criteria: (1) does the rule "create" law; (2) does the rule have a substantial impact upon the regulated industry; (3) does the rule have a substantial impact upon the public; (4) is there a drastic change in the law as it existed before the rule was issued; (5) is there a need for the agency to educate itself.

Thus, the Second Circuit in *Lewis-Mota v. Secretary of Labor*, 469 F.2d 478, 481-2 (1972) held that a rule which "changed existing rights and obligations" and had a "substantial impact" upon segments of the public was subject to the requirements of section 553. So too did the Third Circuit in *Texaco v. Federal Power Commission*, 412 F.2d 740, 744 (1968), cited by the dissent in the instant case. Both Circuits also found need for the agencies to educate themselves before establishing rules and procedures which have a substantial impact on those regulated, under the rationale of *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969). Similar reasoning has been applied by a number of district courts

to strike down agency rules promulgated without regard to the requirements of section 553.[5]

Implicit in these decisions is the fundamental notion that before a governmental agency acts with impact upon existing rights and legitimate expectations of people, the government must give those people an opportunity to be heard. Section 553 of the APA is the mechanism which Congress has chosen for that function. See, *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969).

The panel majority ignored the effect that Revenue Ruling 69-545 had upon the availability of hospital services for millions of persons without the means to pay for in-patient care at hospitals by, an agency which was admittedly not an expert in health care delivery problems and thus needed to be educated. While recognizing that the ruling reversed the long-standing position of IRS as well as the established position of the federal courts on the subject, the panel majority found the criteria applied by the Third and Second Circuits irrelevant because the agency contended that the ruling was "interpretative" and only legally binding if courts chose to accept the interpretation. The panel majority thus seriously departed from the principles upon which two other Circuits and other federal courts have determined whether rule-making is subject to the requirements of section 553. This conflict between the Circuits as to standards to be applied to agency rule-making action should be resolved by this Court.

2. Even if IRS was not obligated to follow the specific rule-making requirements of section 553 of the APA, the agency

[5] See, *Kelly v. Department of Interior*, 339 F.Supp. 1095 (E.D.Cal., 1972); *Pharmaceutical Manufacturers Association v. Finch*, 307 F.Supp. 858 (D.Del., 1970); *Hou Ching Chow v. Attorney General*, 362 F.Supp. 1288 (D.D.C., 1973); *National Motor Freight Traffic Association v. United States*, 268 F.Supp. 90 (D.D.C., 1967); *Seaboard World Airlines, Inc. v. Gronouski*, 230 F.Supp. 44 (D.D.C., 1964).

still was required to consider all relevant factors and indicate its conclusions in some record reviewable by the courts. E.g., *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416 (1971); *Shannon v. Department of Housing and Urban Development*, 436 F.2d 809, 819-20 3rd Cir., 1970) and *Scenic Hudson Preservation Conference v. F.P.C.*, 354 F.2d 608, 612, 620 (2nd Cir., 1965). The decision below is inconsistent with this basic precept of administrative law.

On its face Revenue Ruling 69-545 makes no reference whatsoever to a consideration of the needs of the indigent for free hospital care (See Appendix H. pp. 67a-72a, *infra*). The sole basis for the removal of the free service requirement was a reference to Scott on Trusts. Trust law, however, is concerned with private claims over the assets of a decedent which has been placed into trust into perpetuity, and not federal policy over tax exemptions[6] or the national policy which continues to require that hospitals provide free services to poor people (see point 4, *infra*). IRS never considered the factual underpinnings for the unsubstantiated conclusion "of a changed health care situation in this country" as suggested by the panel majority. There is no record that IRS ever considered the full implications of eliminating the right of the poor to in-patient services in the absence of dire medical emergencies.[7] IRS never considered the effect of eliminating in-

[6] The underlying rationale for the "charitable" tax exemption is that governments must perform certain functions if private parties do not, and thus the use of tax incentives to subsidize such work by private parties "lessens the burdens of government." See House Report No. 1860, 75th Cong., 3rd Sess. 19-20 (1939). See also Treas. Reg. 1-501(c)-1(d)(2).

[7] The Supreme Court has recognized what IRS and the panel majority did not recognize:

> "To allow a serious illness to go untreated until it requires emergency hospitalization is to subject the

(continued)

patient care as a requirement of charitable status of hospitals in "lessening the burdens of government." The uncontradicted Affidavits in the record suggest the seriousness of this omission.[8]

In *Scenic Hudson* the Second Circuit held that an agency must make its decision upon a complete record and has an affirmative duty to inquire into and consider all relevant factors. (354 F.2d at 620). In *Shannon* the Third Circuit held that an agency must utilize some institutionalized method in exercising its duties to assure that all the relevant factual information is before it. (436 F.2d at 819-20). In issuing Revenue Ruling 69-545, however, IRS did not adhere to that requirement.

This Court in *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416 (1971) already has implied an adoption of the position of the Second Circuit in *Scenic Hudson* and the Third Circuit in *Shannon*. It has furthermore made clear in *Citizens to Preserve Overton Park* and other decisions that it is improper for the courts to rely on grounds neither relied upon or developed at the administrative level, or particularly the court's own initial appraisal of the relevant economic and social considerations, to sustain federal regulations. E.g., *SEC v. Chenery Corp.*,

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[7] (continued)

> sufferer to the danger of a substantial and irrevocable deterioration in his health. Cancer, heart disease, or respiratory illness, if untreated for a year, may become all but irreversible paths to pain, disability, and even loss of life. The denial of medical care is all the more cruel in this context, falling as it does on indigents who are often without the means to obtain alternative treatment." *Memorial Hospital v. Maricopa County*, _____ U.S. _____, 94 S.Ct. 1076, 1083 (1974).

[8] In particular see the Affidavits relating to the death of Clifford Breaux, (J.A. 102-105) and those from the physicians at the publicly-operated Charity hospital in Louisiana (J.A. 109-127).

318 U.S. 80 (1943); cf. *Camp v. Pitts*, 411 U.S. 138 (1973). The speculation of the panel majority cannot subsitute for the lack of consideration of relevant factors by IRS. It represents a serious departure by this Circuit from the proper judicial role in reviewing agency action.

3. The decision by the panel majority finding permissible the elimination by respondents of the requirement that nonprofit hospitals must afford service to the indigent in order to retain their "charitable" tax status conflicts with the principles set forth in every federal and tax court decision on the subject decided since 1942. This holding is of broad public importance which warrants review by this court.

In *Commissioner of Internal Revenue v. Battle Creek*, 126 F.2d 405 (5th Cir., 1942) That Court defined a "charitable" hospital under the Code as one which may

> "... charge those able to pay for services rendered, in order to pay the expenses of the institution, *while not denying treatment to others unable to pay anything*. Such institutions are classed as charitable." (at 406). (Emphasis supplied).

The Fifth Circuit rejected the contention by the Commissioner that a hospital which charged some persons able to pay was not entitled to status as a charitable hospital under a predecessor section of the Code, as the hospital in that case did not deny treatment to other persons unable to pay. The record demonstrated that a significantly large percentage of its patients received services, on both an inpatient and outpatient basis, free or below cost.

Every subsequent decision by the tax or other federal courts on the subject since then has required that charitable hospitals do not deny admission and services to persons unable to pay. *Inter-City Hospital Association v.*

Squire, 56 F. Supp. 472 (W. D. Wash., 1944); *Davis Hospital, Inc.*, 4 CCH Tax Ct. Memo. 312 (1945); *Goldsby King Memorial*, 3 CCH Tax Ct. Memo. 693 (1944); *Lorain Avenue Clinic*, 31 T.C. 141 (1958); *Robert Olney*, 17 CCH Tax Ct. Memo. 982 (1958); *Sonora Commuunity Hospital*, 46 T.C. 519 (1966) aff'd per curiam, 397 F.2d 814 (9th Cir., 1968). See also *Harding Hospital v. United States*, 505 F.2d 1068 (6th Cir., Nov. 1974).[9] In every one of these cases the amount of free care rendered by the hospital was decisive to its retention of its "charitable" tax status.

In 1956, the IRS had codified the position in a revenue ruling (Rev. Rul. 56-185, 1956-1, Cum. Bull. 202, Appendix I, *infra*, pp. 73a-76a). That revenue ruling specifically stated that a hospital could qualify for tax exempt status only if it was "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." However, by Revenue Ruling 69-545, the Commissioner, who in 1942 wanted to deny charitable status to hospitals which did not admit and treat *everyone* free, has legislated that charitable hospitals need not admit and treat *anyone* free, and specifically repudiated this portion of the 1956 ruling.

The panel majority acknowledged the judicial and administrative history, but upheld the departure by IRS from that position upon two bases: (1) an irrelevant and incorrect analogy to trust law that "charitable" institutions

[9] In *Harding Hospital* the Sixth Circuit, in a decision issued after the one below, while specifically avoiding the issue of the legality of Revenue Ruling 69-545 (which it noted was in issue in the instant case but had not been briefed to it), predicated its determination that the hospital was not entitled to charitable status upon an accumulation of factors, the major one being the *de minimus* amount of free service afforded to the indigent.

do not have to serve the poor,[10] and (2) a totally unsubstantiated conclusion, not based upon any record, and not even considered by IRS, that economic, social and technological precepts and values now dictate other health policies (*infra*, p. 24a).

The writ should be granted to resolve the conflict between the recent ruling by respondents found "permissible" by the District of Columbia Circuit and the principles set forth in every other relevant decision of the federal courts.

4. The panel majority has decided an important federal question which has an impact upon the availability of hospital services for some 20 to 40 million persons. It did so upon unsubstantiated conclusions which conflict with federal policy.

Although the respondents admit that their "experience in the area of health care is severely limited" (Def. Brief in the Court of Appeals, p. 72), they did not develop a record or consider the health policy of the nation as expressed by Congress and the Agency which Congress charged with administering the nation's health policy, the Department of Health, Education and Welfare. Similarly, the panel majority did not indicate how they came to their various conclusions on the current nature of the health delivery system, including that "in the final analysis, Revenue Ruling 69-545 may be of greater benefit to the poor than its

[10] The conclusions which Scott draws, and the cases upon which the claim is made that promotion of health is a charitable purpose, do not support the thesis that service to the poor is not a requirement. Many of the cases cited in the long footnote in the Scott treatise actually spell out the requirement that the poor as well as the rich be treated in charitable hospitals. *E.g.*, *Hart v. Taylor*, 301 Ill. 344, 133 N.E. 857, 858 (1922); *O'Brien v. Physicians' Hospital*, 96 Ohio St. 1, 116 N.E. 975, 977 (1917). The cases, rather than eliminating free service as an essential element, support the proposition that health is a purpose which may be charitable, provided that actual charity is bestowed.

predecessor Ruling 56-185." (App. C., p. 27a, *infra*). No consideration was given to the number of indigent persons who would be deprived of inpatient hospital care because of a lack of any public or private third party coverage, a matter which concerns HEW greatly. In this regard, in 1971, HEW commented thus:

> ". . . while employer plans cover a majority of the population, they do not protect all of the working population, particularly the working poor. In addition, some of the plans cover the workers but not their dependents. Eligibility for Medicaid also poses financial barriers. Eligibility varies widely among the States, many of which exclude the working poor and adults in families headed by a male. Under these circumstances, half of the families with incomes under $5,000 a year and two-thirds of the families with incomes under $3,000 have no insurance. Others excluded from protection are: children and mothers in low-income and middle-income families; the unemployed and their dependents; lower income self-employed people; employed people (mainly the working poor) whose employers offer no health plans; and migrant seasonal workers."[11]

[11] "Towards a Comprehensive Health Policy for the 1970's, A White Paper," May 1971, U.S. Department of Health, Education and Welfare, p. 16.

Using these figures and those of the Census Bureau from the 1970 census, (General Social and Economic Characteristics, U.S. Summary, PC(1)-C1, Table 182), there are at least 36 million persons in the United States with incomes below $5,000 a year, at least half of whom have no public or private health insurance according to HEW. Moreover an undetermined number of families with incomes between $5,000 and

(continued)

Although Medicaid theoretically was designed to provide coverage for the indigent, it has been largely confined to the categorical public assistance recipients, and in approximately half the States (by the States' option) to persons who fit into the categories but for income which, at its maximum, would not exceed 133% of the maximum grant level for the particular State. Not only are millions of equally indigent persons not covered because they do not fit into one of the categories (aid to dependent children, aid to the aged, aid to the blind, aid to the totally disabled) but in most States the maximum grant level is so low that millions of persons below the subsistence level are excluded.[12] In Louisiana, for example, where petitioners Hunter, Cook and Lampton reside, eligibility for Medicaid is limited to the welfare class, and the cut-off for eligibility for welfare, as of July 1974, was $1,464 per year (See App. J, *infra*, p. 78a).

Further, HEW and Congress have both reaffirmed the long-standing obligation of hospitals to give charitable care. While in the courts below IRS was "defending" its abandonment of the charitable obligations of hospitals to the millions of uninsured indigent and medically indigent

[11] (continued)
admission to most hospitals under Revenue Ruling 69-545. Had IRS held a rule-making hearing such information should and would have become part of the record. As suggested by the dissent, upon such a record Revenue Ruling 69-545 would not have issued.

[12] See Appendix J, *infra*, pp. 77a-79a. Note that 24 States limit their eligibility to the welfare categories. Although the other States may cover medically needy persons who would be eligible for welfare but have incomes up to 133% of the welfare level, according to the records of HEW most States with medically needy programs only include persons with incomes slightly above the welfare line. Maximum income for eligibility exists in New York, with a level of $5000 a year for a family of four (Division of Evaluation, Medical Services Administration, DHEW, Income and Resources Levels for Medically Needy, DRAFT, December 1974).

persons on the unsubstantiated claim that in large measure they no longer existed, HEW was reaffirming the charitable obligations of those hospitals (including a substantial number of nonprofit hospitals) which had received Hill-Burton construction monies. In July 1972 and June 1973 HEW promulgated regulations setting forth more specific obligations of these hospitals to serve the indigent.[13] And Congress more recently, in December 1974, reaffirmed the obligations of such hospitals by the passage of Title XVI of the Public Health Service Act, continuing the past obligations and reaffirming new obligations for all future grantees.[14]

5. A multiplicity of lawsuits may be anticipated on these issues in other federal courts. In 1974 indigent persons instituted similar action in federal district courts in Ohio and Massachusetts.[15] In other jurisdictions where the Medicaid level is low (See Appendix J *infra*, pp. 77a-79a) and/or unemployment with its consequential loss of health insurance coverage continues to rise, persons needing hospital care may be faced with non-admission by the nation's nonprofit hospitals and turn to additional federal courts for redress. The split in the court below in the instant case, and the departure from precedent exhibited by the majority, suggests that the matter is quite open. In view of the potential size and gravity of the problem, a consideration of the issues should now be undertaken by this Court.

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[13] 42 CFR 53.111.

[14] National Health Planning and Resources Development Act of 1974, P. Law 93-641, sections 1602(5) and (6), 1604(b)(1)(J), 1612(c), 93rd Cong., 2d Sess.

[15] *Lugo, et al., v. Simon, et al.*, C74-345, NDOhio; *Chapman et al., v. Berkshire Medical Center, et al.*, Civ. 74-1954F, D.Mass.

CONCLUSION

For the foregoing reasons a Writ of Certiorari should be granted.

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 74-1293

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL

v.

WILLIAM E. SIMON, SECRETARY OF TREASURY, ET AL., APPELLANTS

Before: BAZELON, *Chief Judge;* WRIGHT, MCGOWAN, TAMM, LEVENTHAL, ROBINSON, MACKINNON, ROBB AND WILKEY, *Circuit Judges.*

Filed December 6, 1974

ORDER

Appellees' suggestion that the matter be considered *en banc* having been circulated to the full court, and there not being a majority of the judges in regular active service in favor of having this case reheard *en banc,* it is
ORDERED by the court *en banc* that appellees' aforesaid suggestion is denied.

Per Curiam

Statement of BAZELON, *Chief Judge,* with whom Circuit Judges WRIGHT and ROBINSON concur, as to why he voted to grant rehearing *en banc.*

Statement of WRIGHT, *Circuit Judge*, with whom Chief Judge BAZELON and Circuit Judge ROBINSON concur, as to why he voted to grant rehearing *en banc*.
Statement of BAZELON, *Chief Judge*, as to why he voted to grant rehearing *en banc*:

I concur in Judge Wright's dissent and statement as to why he voted to grant rehearing *en banc* on the issue of compliance with the rulemaking procedures of the Administrative Procedure Act, 5 U.S.C. § 553 (1970). I add only this further thought. The panel opinion concedes, as it must, that rulemaking procedures are required if Rev. Rul. 69-545 has an "independent binding effect." If the Rev. Rul. were no more than "an opinion of the legal staff" of the Treasury,[1] I might agree with the majority that courts "are not bound by [the Revenue Ruling] unless they choose to accept it" and that, therefore, the Rev. Rul. has no independent binding effect. But in light of the traditional deference to Internal Revenue Service regulations in the interpretation of the more general sections of the Internal Revenue Code of 1954,[2] I think it a truly heroic assumption

[1] American President Lines, Ltd. v. Federal Maritime Comm'n, 316 F.2d 419, 422 (D.C. Cir. 1963). *See* Hou Ching Chow v. Attorney-General, 362 F. Supp. 1288, 1292 (D.D.C. 1973); Continental Oil Co. v. Burns, 317 F. Supp. 194 (D. Del. 1970). *Cf.* Pacific Gas & Elec. Co. v. FPC, Nos. 73-1358, -1485 (D.C. Cir. June 26, 1974) at 8-9 n.14, 10-13 (slip opinion); Lewis-Mota v. Secretary of Labor, 469 F.2d 478 (2d Cir. 1972); California Citizens Band Ass'n v. United States, 375 F.2d 43 (9th Cir.), *cert. denied*, 389 U.S. 844 (1967). There is nothing in Gibson Wine Co. v. Snyder, 194 F.2d 329 (D.C. Cir. 1952), which is inconsistent with these cases. There is, I think no one would doubt, a very substantial difference between regulations defining a type of grape and regulations interpreting such legislative phrases as "the public interest" or "tax avoidance purpose."

[2] *See* United States v. Cartwright, 411 U.S. 546, 550 (1973); Bingler v. Johnson, 394 U.S. 741, 749-51 (1969); Comm'r v. South Texas Lumber Co., 333 U.S. 496, 501 (1948); Comm'r v. O. Liquidating Co., 292 F.2d 225, 231 (3d Cir.), *cert. denied*, 368 U.S. 898 (1961); Kern v. Granquist, 291 F.2d 29, 32 (9th Cir. 1961). *Compare* Kurzner v. United States, 413 F.2d 97, 112 (5th Cir. 1969) *with* O'Neill v. United States, 410 F.2d 888 (6th Cir. 1969).

that courts will not be bound by the Ruling "unless they choose to accept it." Indeed, this tradition of deference informs the panel majority's own approach to the legality of Rev. Rul. 69-545. The majority does not review the issue *de novo* but instead concludes that the Ruling "is founded on a *permissible* definition of the term 'charitable' and is not contrary to any *express* Congressional intent."[3] If the majority were to review the issue *de novo*, it would, I take it, certainly want more information than is contained in the record before us here. And it is for expressly that reason, as Judge Wright so persuasively argues, that rulemaking hearings are required.[4] So the majority tells the plaintiffs that it will not be bound by the Internal Revenue Service interpretation of the term "charitable" and then turns right around and upholds the Service interpretation as a permissible exercise of discretion on the basis of factual assumptions which are not supported by a record and which plaintiffs have not had an opportunity to rebut. I will not concur in such reasoning.

[3] Slip op. at 23 (emphasis added).

[4] *See also* NLRB v. Wyman-Gordon Co., 394 U.S. 759, 775-80 (1969) (Douglas, J. dissenting).

Statement of *Circuit Judge* WRIGHT as to
Why He Voted to Grant Rehearing *En Banc*

Revenue Ruling 69-545, which the panel majority upholds, replaced Revenue Ruling 56-185 which provided that a hospital could qualify for tax exempt status only if it was "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." Revenue Ruling 69-545 provides: "Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost." Thus Revenue Ruling 69-545 worked a substantial change in the availability of hospital services for the poor. Yet, admittedly, neither the poor nor anyone else was given notice of the proposed change or allowed to comment on it.

On the basis of assumed social, economic, and technological changes in the need of the poor for free medical care, the panel majority approves Revenue Ruling 69-545. The record in this case does not reflect what the needs of the poor for free medical care really are because the Internal Revenue Service did not comply with the rule-making procedures required by Section 553 of the Administrative Procedure Act, 5 U.S.C. §553 (1970). Thus millions of poor people are effectively denied medical care without the procedural protections provided by law. If these procedural protections had been provided, doubtless it would have been disclosed that millions of Americans are indeed too poor to pay for hospital services and have no means of obtaining those services except as charity patients at our nonprofit hospitals. With this fact established as a matter of record, I confidently believe that Revenue Ruling 69-545 would never have been promulgated in the first place.

I would affirm the District Court in this case for the reasons stated in its opinion holding Revenue Ruling 69-545 invalid (*see Eastern Kentucky Welfare Rights*

Organization v. *Shultz*, D.D.C., 370 F. Supp. 325 (1973)). I would also hold Revenue Ruling 69-545 invalid because it was issued without compliance with the rule-making procedures required by Section 553 of the Administrative Procedure Act, 5 U.S.C. § 553, as indicated in my dissent to the panel opinion.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 74-1293 **SEPTEMBER TERM, 1974**

Civil Action 1378-71

EASTERN KENTUCKY WELFARE RIGHTS
ORGANIZATION, ET AL

v.

WILLIAM E. SIMON, ET AL
SECRETARY OF TREASURY
APPELLANTS

BEFORE: Wright and Wilkey, Circuit Judges;
Jameson*, U.S. Senior District Judge
for the District of Montana.

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ORDER

On consideration of appellees' petition for rehearing, it is

ORDERED by the Court that appellees' aforesaid petition is denied.

For the Court:

/s/ Hugh E. Kline
HUGH E. KLINE
Clerk

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* Sitting by designation pursuant to Title 28 U.S. Code Section 294(d).

Circuit Judge Wright would grant rehearing for the reasons set forth in his statement as to why he voted to grant rehearing *en banc*.

APPENDIX C

Notice: This opinion is subject to formal revision before publication in the Federal Reporter or U.S. App. D.C. Reports. Users are requested to notify the Clerk of any formal errors in order that corrections may be made before the bound volumes go to press.

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 74-1293

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION,
ET AL.

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,
APPELLANTS

Appeal from the United States District Court
for the District of Columbia
(D.C. Civil No. 1378-71)

Decided October 9, 1974

Wesley J. Filer, Attorney, Tax Division, Department of Justice, of the bar of the Supreme Court of Texas, *pro hac vice*, by special leave of court, with whom *Scott P. Crampton*, Assistant Attorney General, *Earl J. Silbert*, United States Attorney, and *Meyer Rothwacks* and *Leonard J. Henzke, Jr.*, Attorneys, Tax Division, Department of Justice, were on the brief, for appellants.

Marilyn G. Rose, with whom *Joseph Onek*, *Jeffrey B. Schwartz*, *Laurens H. Silver*, and *Anthony Z. Roisman* were on the brief, for appellees.

John A. Beck filed a brief on behalf of American Hospital Association as *amicus curiae* urging reversal.

Before WRIGHT and WILKEY, *Circuit Judges*, and JAMESON,* *Senior District Judge*.

Opinion for the court filed by *Senior District Judge* JAMESON.

Opinion concurring in part and dissenting in part filed by *Circuit Judge* WRIGHT.

JAMESON, *Senior District Judge:* Defendants-appellants, the Secretary of the Treasury and Commissioner of Internal Revenue, have appealed from an order granting summary judgment to plaintiffs-appellees and holding that "private nonprofit hospitals seeking tax exempt status as charitable organizations under § 501 (c)(3) of the [Internal Revenue] Code must provide free or below cost treatment to individuals unable to pay for such services" and that a revenue ruling modifying this requirement is void.[1]

I. BACKGROUND

Sections 501 (a) and (c) (3) of the Internal Revenue Code of 1954 (26 U.S.C. 501(a) and (c)(3)) exempt from federal income tax: "(3) Corporations, and any community chest, fund, or foundation, organized and operated exclusively for charitable . . . purposes, . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual . . .". Other related sections of the Code provide that contributions to such tax exempt charitable organizations are deductible for purposes of computing federal income tax (26 U.S.C. § 170) and estate and gift taxes (26 U.S.C. §§ 2055 (a)(2), 2106 (a) (2) (A) (ii) and 2522 (a) (2)).

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* Of the United States District Court for the District of Montana, sitting by designation pursuant to 28 U.S.C. § 294 (d) (1970).

[1] By order of this court, the American Hospital Association was granted leave to file briefs as *amicus curiae*.

Hospitals and other health organizations have never been expressly categorized as tax exempt organizations and have achieved that status only by qualifying as "charitable" organizations under the Code. Long established Internal Revenue Service (I.R.S.) policy held that hospitals qualified as charitable organizations under 501 (c) (3) only if they provided free or below cost service to those unable to pay. This policy was articulated in Revenue Ruling 56-185, which held that a hospital could qualify for tax exempt status only if it was "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay".[2]

The I.R.S. modified this position in 1969 with the issuance of Revenue Ruling 69-545. The new ruling broadly defines "charitable" in terms of community benefit and holds that the promotion of health constitutes a "charitable purpose" in the "generally accepted legal sense of that term"[3] and within the meaning of §501(c)(3) of the Code. According to the ruling,

> "The promotion of health . . . is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries

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[2] Other pertinent parts of Revenue Ruling 56-185 state: "It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution without denying medical care or treatment to others unable to pay. . . It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. . . . It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services."

[3] As a basis for its conclusion that in the "general law of charity" the promotion of health is a charitable purpose, the I.R.S. relies on RESTATEMENT (SECOND) TRUSTS, sec. 368 and 372, and IV SCOTT ON TRUSTS (3rd.ed. 1967) sec. 368 and 372.

> eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community . . .".

Based on this community benefit concept, a nonprofit hospital can quality as a charitable organization under 501(a)(3) "By operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement . . ." [e.g. private health insurance, Medicare, or Medicaid]. Thus, for a hospital to qualify as a tax exempt organization, the provision of free or below cost service to those unable to pay is no longer essential.[4]

Alleging harm from this new ruling, the plaintiffs-appellees, a group of health and welfare organizations and indigent persons, brought this action seeking to declare Revenue Ruling 69-545 invalid and to enjoin its implementation. They submitted affidavits recounting incidents in various parts of the country involving the denial of hospital services to indigents by institutions enjoying tax exempt status as "charitable" organizations.

Plaintiffs contended that (1) the Revenue Ruling constitutes an improper administrative alteration of the Internal Revenue Code in contradiction of long-standing Congressional tax policy and judicial interpretation; (2) the Ruling was not properly adopted due to the I.R.S. failure to grant interested parties an opportunity to be heard, allegedly a violation of the Administrative Procedure Act and the Fifth Amendment right of due process; and (3) the Ruling was an "abuse of discretion".

The defendants moved for dismissal of plaintiffs' complaint on the ground that the court lacked jurisdiction to

[4] Revenue Ruling 69-545 expressly states: "Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost".

entertain the action. The court denied this motion without opinion. Subsequently, upon the parties' cross motions for summary judgment, the court granted summary judgment in favor of the plaintiffs.

The court held:

(1) The plaintiffs have standing to maintain this action because they "have demonstrated sufficient injury flowing from the issuance of Revenue Ruling 69-545" and fall within the zone of interests protected by the Code.[5]

(2) The Federal tax exemption to the Declaratory Judgement Act, 28 U.S.C. § 2201, and the Tax Injunction Act, 26 U.S.C. § 7421 (a), do not bar the suit.

(3) Judicial review of the Revenue Ruling is not precluded by the Administrative Procedure Act's provision in 5 U.S.C. § 701 (a) (2) which forbids review of "agency action . . . committed to the agency discretion by law".

(4) The new Revenue Ruling does not comport with Congressional intent but rather is clearly contrary to the relevant judicial, legislative and administrative history on the matter. In light of this, the "community benefit" theory cannot "justify the basic shift in policy". The promulgation of the new ruling was therefore unauthorized.

Contentions on Appeal

Appellants level a dual attack against the judgement. First, they contend that the district court lacked jurisdiction in that the action is barred by (a) sovereign immunity, (b) the Anti-Injunction Act and the tax exemption to the Declaratory Judgment Act, and (c) the Administrative

[5] The district court, with respect to standing, noted that generally an action challenging a ruling of the Internal Revenue Service is in the nature of a refund action. The ruling challenged in this instance, however, is not one that will produce protesting taxpayers. The court concluded that this should not "immunize the Ruling" from judicial scrutiny, especially where, as here, the plaintiffs belong to a class of people whom the relevant sections of the Code purport to benefit.

Procedure Act.[6] Second, appellants argue that Revenue Ruling 69-545 was authorized and does meet the charitable standard of § 501 (c) (3) of the Code. In addition to opposing the contentions of appellants, appellees argue that the Revenue Ruling was not promulgated in accordance with the notice and hearing requirement of the Administrative Procedure Act and constitutes an abuse of discretion.

II. JURISDICTION

(a) *Sovereign Immunity*

The defense of sovereign immunity is jurisdictional. *See United States* v. *Sherwood*, 312 U.S. 584, 61 S.Ct. 767, 85 L.Ed. 1058 (1941). Generally, without specific authority, a court may not entertain an action against the sovereign. That doctrine, however, is not without its exceptions. The two primary exceptions were delineated in *Larson* v. *Domestic and Foreign Corp.*, 337 U.S. 682, 69 S.Ct. 1457, 93 L.Ed. 1628 (1949): sovereign immunity will not serve to bar jurisdiction when (1) the actions of a government official are beyond the scope of his authority or (2) "the statute or order conferring power upon the officer to take action in the sovereign's name is claimed to be unconstitutional". *Id.* at 689-690; *accord Dugan* v. *Rank*, 372

[6] The American Hospital Association in its *amicus* brief and appellants in note 46 of their brief contend also that appellees do not have standing because they have failed to demonstrate injury by an agency to an interest protected by the Code. This issue was discussed at length in the opinion of the district court. We agree with the court's conclusion that appellees made a sufficient showing of "injury in fact" to an interest "arguably within the zone of interests to be protected or regulated". *See, Sierra Club* v. *Morton*, 405 U.S. 727, 733, 92 S.Ct. 1361, 31 L.Ed.2d 636 (1972); *United States* v. *Students Challenging Regulatory Agency Procedures*, 412 U.S. 669, 93 S.Ct. 2405, 37 L.Ed.2d 254 (1973).

U.S. 609, 621-622, 83 S.Ct. 999, 10 L.Ed.2d 15 (1963). Here plaintiffs alleged, and the district court found, that government officials had acted beyond their statutory power.

Appellants contend that (1) regardless of exceptions that may have been formulated in other judicial areas, sovereign immunity in matters of federal tax remains an absolute bar; (2) even if the *Larson* exceptions are viable in tax cases, the Commissioner was authorized by statute to interpret the term "charitable" as he did; and (3) mere error by the Commissioner in his interpretation of "charitable" would not negate the application of sovereign immunity, *Larson*, *supra* at 690.

Appellants rely on *Louisiana* v. *McAdoo*, 234 U.S. 627, 34 S.Ct. 938, 58 L.Ed. 1506 (1914) in support of their contention that the defense of sovereign immunity is absolute with respect to the area of federal taxes. *McAdoo* involved an action against the Secretary of the Treasury brought by the State of Louisiana as a sugar producer. Louisiana challenged the Secretary's determination of the tariff rates to be applied to sugar imported from Cuba. The Court held that the defense of sovereign immunity barred the action regardless of the fact that the State of Louisiana claimed that the action of the Secretary was not authorized by law.

McAdoo, however, must be viewed in its proper perspective. The Court decided that case in 1914. Since then, significant changes have occurred in the area of standing, and exceptions to the doctrine of sovereign immunity have been judicially recognized. *Larson* and *Dugan*, *supra*. Moreover, with the advent of the Administrative Procedure Act in 1946, the continued viability of sovereign immunity with respect to administrative actions has been seriously questioned. *Scanwell Laboratories, Inc.* v. *Shaffer*, 424 F.2d 859, 873 (D.C. Cir. 1970).

The exceptions to the doctrine of sovereign immunity set forth in *Larson* have been applied in federal tax cases. In *McGlotten* v. *Connally*, 338 F.Supp. 448 (D. D.C. 1972), a

nontaxpayer challenged the exempt status of a fraternal organization with racially discriminatory memebership policies. The three-judge court rejected a sovereign immunity argument, holding that the "action falls readily within the two long-standing exceptions to that doctrine". *Id.* at 454, n. 27.[7] This court recognized the application of those exceptions in *Americans United* v. *Walters*, 477 F.2d 1169 (1973), reversed on other grounds *sub nom. Alexander* v. *Americans United*, _____ U.S. _____, 94 S.Ct. 2053 (1974).[8]

The Government is correct in contending that "a claim of error" in the exercise of an officer's powers is not sufficient to invoke the scope of authority exception to the sovereign immunity doctrine. *Larson, supra* at 690. Plaintiffs in this case, while not challenging the fact that the Secretary or Commissioner has the authority to prescribe rules and regulations for the administration of the revenue laws, nevertheless do challenge the authority of the Commissioner to interpret a revenue statute in a manner contrary to long-established Congressional policy. Thus, more than mere error on the part of the Commissioner is alleged. The court, therefore, has jurisdiction to determine whether or not the action of the Commissioner was authorized. The court has jurisdiction to determine its jurisdiction, *Land* v. *Dollar*, U.S. 731, 739 (1947), even though such a determination requires a decision on the merits. *Larson, supra* at

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[7] The Government argues that *McGlotten* is either wrong or distinguishable in that it involved racial discrimination, a judicially sensitive issue. That the racial aspect was the controlling factor in the court's determination of *McGlotten* is not supported by the language of the decision.

[8] See also *Green* v. *Kennedy*, 309 F.Supp. 1127 (D. D.C. 1970), continued *sub nom. Green* v. *Connally*, 330 F.Supp. 1150 (D. D.C. 1971), *aff'd per curiam sub nom. Coit v. Green*, 404 U.S. 997, 92 S.Ct. 564, 30 L.Ed.2d 550 (1971); *Junior Chamber of Commerce of Rochester, Inc.* v. *The United States Jaycees*, 495 F.2d 883 (10 Cir. 1974).

690; *Bell* v. *Hood*, 327 U.S. 678, 682-683, 66 S.Ct. 773, 90 L.Ed 939 (1946); *Junior Chamber of Commerce, supra.*

That sovereign immunity does not serve as a bar to the present action is further established by this court's position that the Administrative Procedure Act constitutes a waiver of sovereign immunity. Quoting from *Estrada* v. *Ahrens*, 296 F.2d 690, 698 (5 Cir. 1961) this court in *Scanwell, supra* at 873 stated:

> "By providing judicial review in an action brought by 'any person adversely affected or aggrieved by any agency action' Congress permitted suits which under established tests would certainly be barred as suits against the government . . . . The Act thereby makes a clear waiver of sovereign immunity in actions to which it applies."

We conclude that the district court correctly held that the action was not barred by the doctrine of sovereign immunity.

(b) *Anti-Injunction and Declaratory Judgement Acts*

The Anti-Injunction Act (26 U.S.C. § 7421 (a)) provides in relevant part: ". . . no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed". In *Bob Jones University* v. *Simon*, _____ U.S. _____, 94 S.Ct. 2038, 2046 (1974), the Court stated:

> "The Court has interpreted the principal purpose of this language to be the protection of the Government's need to assess and collect taxes as expeditiously as possible with a minimum of pre-enforcement judicial interference, 'and to require that the legal right to the disputed funds to be determined in suit for a refund.' *Enochs* v. *Williams*

Packing and Navigation Co., 370 U.S. 1, 7, 82 S.Ct. 1125, 1129, 8 L.Ed.2d 292 (1962)."

Here, the plaintiffs as nontaxpayers seek to have the I.R.S. enjoined from granting tax exempt status to hospitals which fail to provide free or reduced-charge services to indigents. The case of *McGlotten* v. *Connally*, *supra* is analogous. In *McGlotten* a black American brought a class action "to enjoin the Secretary of the Treasury from granting tax benefits to fraternal and nonprofity organizations which exclude non-whites from membership". *Id.* at 450. In rejecting the contention that the Anti-Injunction Act barred the suit, the court concluded that the action had "nothing to do with the assessment or collection of taxes. He [the plaintiff] does not contest the amount of his own tax, nor does he seek to limit the amount of tax revenue collectible by the United States. The preferred course of raising his objections in a suit for a refund is not available. In this situation we cannot read the statute to bar the present suit." *Id.* at 453-454.

The *McGlotten* rationale was followed by this court in *Americans United* v. *Walters*, 477 F.2d 1169 (1973) in holding that a corporation in challenging the revocation of its tax exempt status was not attempting to restrain the assessment or collection of taxes. The Supreme Court, however, in *Alexander* v. *Americans United, Inc.*, ____ U.S. ____, 94 S.Ct. 2053 (1974) reversed. The Court held that the purpose of the suit was to restrain the collection of taxes from contributors to the corporation. Accordingly, the Anti-Injunction Act applied and barred the action. The Court further stressed that an adequate legal remedy existed in the form of refund litigation.

Americans United, however, did not involve the factual situation presented in *McGlotten* and in this action. Here, as in *McGlotten*, rather than attempting to negate the levy of a tax, the plaintiffs are seeking to force the Government to impose a tax on contributions to certain hospitals. This, therefore, is not a case wherein the Government is faced

with any threat to the actual assessment or collection of the taxes to which it deems itself entitled.

In addition, there is merit in the claim that there is not other adequate legal remedy.[9] Obviously neither the tax exempt charitable hospitals nor their contributors will institute refund litigation, as the contributions are tax free. It is apparent from a close analysis of the Anti-Injunction Act that it did not contemplate barring actions, such as this, where the litigation did not threaten to deny anticipated tax revenues to the Government.

Appellants next contend that, even if the Anti-Injunction Act is held inapplicable, the tax exemption provision of the Declaratory Judgment Act (28 U.S.C. § 2261) bars the action. That provision authorizes federal courts to grant declaratory judgments "except with respect to Federal taxes". Appellants argue that the Declaratory Judgment Act is much broader in scope than the Anti-Injunction Act.

In *McGlotten*, *supra*, the court concluded that the Anti-Injunction Act and Declaratory Judgment Act are coterminous. The court in *Americans United*, *supra*, following the rationale of *McGlotten*, held that while the tax exemption provision of the Declaratory Judgment Act is literally broader than the Anti-Injunction Act provision, nevertheless the two are coterminous. The court reasoned that it would be paradoxial to authorize injunctive relief in some cases "while depriving courts the authority to declare the rights of the parties in connection with the injunctive relief". *Id.* at 1176.

Although the Supreme Court reversed *Americans United*, it did not deal with the issue of whether or not the Declaratory Judgement Act was broader than the Anti-

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[9] In *Bob Jones*, *supra* at 2050, the Court stated: "This is not a case in which an aggrieved party has no access at all to judicial review. Were that true, our conclusion might well be different."

Injunction Act.[10] A re-examination of the legislative history of the tax exemption provision leads this court to conclude, as it did in *Americans United*, that the Declaratory Judgment Act and the Anti-Injunction Act were intended to be coterminous.[11] Therefore, just as the Anti-Injunction Act does not bar this action, neither does the Declaratory Judgment Act.

(c) *Administrative Procedure Act*

In contending that the Administrative Procedure Act precludes this action, appellants rely on 5 U.S.C. 701 (a) (1), which indicates that administrative actions are not subject to review "to the extent that statutes preclude judicial review". With respect to this exception, the Supreme Court

[10] With respect to the question of whether the Declaratory Judgment Act is coterminous with the Anti-Injunction Act, the Court stated: "While we take no position on this issue, it is in any event clear that the federal tax exception to the Declaratory Judgment Act is at least as broad as the prohibition of the Anti-Injunction Act". 94 S.Ct. at 2057-2058, n. 10.

[11] When the Declaratory Judgment Act was passed in 1934, the Act did not contain the phrase "except with respect to Federal taxes", which now appears in § 2201. Some taxpayers used the Declaratory Judgement Act to do what they were prohibited from doing under the Anti-Injunction Act. *See, e.g. Penn* v. *Glenn*, 10 F.Supp. 483 (W.D. Ky. 1935), *app. dismissed per curiam*, 84 F.2d 1001 (6 Cir. 1936), and *F.G. Vogt and Sons, Inc.* v. *Rothensies*, 11 F.Supp. 225 (E.D. Pa. 1935). Congress reacted to this by amending the Declaratory Judgment Act to include the tax exemption provision (Act of August 30, 1935, Ch. 829, § 405, 49 Stat. 1027). As noted by this court in *Americans United, supra* at 1176:

"The Senate Finance Committee, in reporting out the amended version, stated that the 'application of the Declaratory Judgments Act to taxes would constitute a radical departure from the long-continued policy of Congress [as represented today by § 7421 (a)] with respect to the determination, assessment, and collection of Federal taxes.'"

With this legislative history it appears clear that Congress intended the Declaratory Judgment Act § 2201 to be coterminous with the Anti-Injunction Act.

has held that access to judicial review will generally not be denied unless there is a showing by "clear and convincing evidence" of a contrary legislative intent. *Rusk* v. *Cort*, 369 U.S. 367, 379-380 (1962). Appellants argue that the Anti-Injunction Act, the tax exception to the Declaratory Judgment Act and the doctrine of sovereign immunity, combined with specific procedures established by Congress for review of tax matters, all indicate Congressional intent to "preclude judicial review".

We have concluded, however, that the Anti-Injunction Act, Declaratory Judgment Act and sovereign immunity do not bar this action. It is of course true, as appellants contend, that Congress has prescribed procedures for challenging administrative determinations of tax liability. Those procedures, however, are applicable only to cases involving the imposition of a tax, whereas here the challenge is made to a determination that certain hospitals are exempt from taxation as charitable organizations. We find no "clear and convincing evidence" that Congress intended to preclude judicial review in a case such as this.[12]

If anything, the pertinent Congressional enactments indicate a Congressional intent that the actions of the In-

[12] Appellants rely heavily on *National Railroad Passenger Corp.* v. *National Assn. of Railroad Passengers* ____ U.S. ____, 94 S.Ct. 690 (1974). That case involved the question of whether an organization representing railroad passengers could bring an action to enjoin the discontinuance of certain passenger trains operated by the National Railroad Passengers Corporation (Amtrak). The Court concluded that the private citizens had no right to bring the injunctive action. The case, however, is not in point. There is a significant difference between forcing the Government to incur deficits by requring the continuance of train service and forcing the Government to tax contributions to certain hospitals. Furthermore, in *National Railroad* the legislative history of Amtrak Act indicated a Congressional intent to preclude private causes of action. *Id.* at 694. No such Congressional intent is to be found with respect to the Internal Revenue Code. Finally, Congress in the Amtrak Act expressly provided that the Attorney General should have the right to secure judicial review. Here no judicial review is possible except in an action by the plaintiffs.

ternal Revenue Service be subject to judicial review. The provision for review of the "assessment and collection" of taxes by the I.R.S. are the basis for many hundreds of taxpayer and I.R.S. suits every year. By means of refund and deficiency actions, the courts review the policies, practices, rulings, interpretations and actions of the Internal Revenue Service. Those cases cannot be commenced until after the assessment and collection of taxes. As noted *supra*, the rationale limiting suits to the post-collection period is not applicable in this case. To limit plaintiffs to a refund action under these facts is, as the district court concluded, equivalent to denying them judicial relief. That result is without foundation in the relevant law.

III. VALIDITY OF REVENUE RULING 69-545

In holding that "Revenue Ruling 69-545 was improperly promulgated and is without effect", the district court concluded that "based on relevant judicial, legislative, and administrative decisions" the new Ruling constituted an unauthorized reversal of a long-established policy of requiring exempt hospitals "to offer special financial consideration to persons unable to pay". The court recognized that "as a matter of jurisdiction and efficient tax administration . . . courts have regularly paid deference to the expertise attributed to the I.R.S. in tax related matters and therefore judicial interference has been reluctantly employed". The court continued: "However, this exhibition of restraint is predicated upon the assumption that administrative rulings will do no more than effectuate, implement and clarify the provisions of the Code which have been Congressionally enacted. . . . When this assumption is proven wrong, the courts must act to rectify any administrative determination which is not in accord with the Code."

We do not disagree with these principles of judicial interpretation of administrative rulings, but our own analysis

of the judicial, legislative, and administrative decisions leads to a contrary result. We conclude the Revenue Ruling 69-545 is not inconsistent with 26 U.S.C. § 501 (c) (3) and that the modification of the prior ruling was authorized.

The definition of the term "charitable" has never been static and has been broadened in recent years. Prior to 1959, Treasury Regulations generally defined charitable organizations as those operated for the relief of the poor.[13] In 1959, however, a comprehensive set of regulations interpreting § 501(c)(3) was issued.[14] These regulations adopted a broad concept of "charitable". The key provision, § 1.501(c)(3)-1(d)(2) reads:

> "(2) *Charitable defined.* The term 'charitable' is used in section 501 (c((3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501 (c) (3) of other tax exempt purposes which may fall within the borad outlines of 'charity' as developed by judicial decisions. Such term includes: Relief of the poor and distressed or of the underprivileged; advancement of

[13] *See*, e.g. Treas. Reg. § 39.101 (b)-1 (b) (1939 Code) which stated:

"Corporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor."

See also, I.T. 1800, II-2 Cum. Bull. 152 (1923), a ruling of the Commissioner of the I.R.S., which held that the term "charitable" in the predecessor of Section 501 (c) (3) was used in its more restrictive sense of relief of the poor, rather than its broader legal sense in the law of charities.

[14] Revenue Ruling 56-185 was issued in 1956. Proposed regulations were also initially issued in 1956, repeating the restrictive view of charity contained in Ruling 56-185. (21 Fed. Reg. 460, 464 Jan. 21, 1956). These were withdrawn for more extensive study. The comprehensive set of regulations was proposed early in 1959 (24 Fed. Reg. 1421, 1423 Feb. 26, 1959) and, after public hearings, final regulations were issued, T.D. 6391, (24 Fed. Reg. 5217, 5219 June 26, 1959).

religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organiztions designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human rights secured by law; or (iv) to combat community deterioration and juvenile delinquency."

This Treasury Regulation was cited in *Green* v. *Connally, supra,* wherein the three-judge district court stated with respect to § 501 (c) (3):

> ". . . clearly, the term 'charitable' is used 'in its generally accepted legal sense,' Treas. Reg. § 1.501 (c) (3)-1(d) (2), and not in a street or popular sense (such as, e.g., *benevolence to the poor and suffering*). *See* H. Reiling, 'What is a Charitable Organization?. 44 A.B.A.J. 525, 527 (1958). Thus, 'strong analogy' can be derived from the general common law of charitable trusts, at least for close interpretative questions." 330 F.Supp. at 1157. (emphasis added).[15]

In promulgating Revenue Ruling 69-545, the Commissioner did rely on an analogy to the law of charitable trusts. As indicated earlier, the Commisioner cited both the RESTATEMENT (SECOND) OF TRUSTS (3rd ed. 1967) sec.

[15] The court said in part: "Changes in the courts' conceptions of what is charitable are wrought by changes in moral and ethical precepts generally held, or by changes in relative values assigned to different and sometimes competing and even conflicting interests of society." *Id.* at 1159.

368 and sec. 372[16] in holding that the promotion of health is a charitable purpose within the meanIng of § 501(c) (3).

The term "charitable" is thus capable of a definition far broader than merely the relief of the poor. The law of charitable trusts supports the borader concept. The question involved here then is whether the term "charitable" as used in § 501 (c) (3) may be broadly interpreted as was done in Revenue Ruling 69-545 or is to be restricted to its narrow sense of relief of the poor.

We cannot conclude, as did the district court, that Congress intended the latter construction. While it is true that in the past Congress and the federal courts have conditioned a hospital's charitable status on the level of free or below cost care that it provided for indigents,[18] there is no authority for the conclusion that the determination of

[16] The RESTATEMENT (SECOND) OF TRUSTS sec. 368 (1959) states:

"Charitable purposes include:

(a) the relief of proverty;
(b) the advancement of education;
(c) the advancement of religion;
(d) *the promotion of health;*
(e) governmental or municipal purposes;

(f) other purposes the accomplishment of which is beneficial to the community." (emphasis added).

[17] SCOTT ON TRUSTS, 3rd.Ed. sec. 368, p. 2853 states "It is well settled that the promotion of health is a charitable purpose". Later in his treatise, Professor Scott observed that "a trust for the promotion of health, however, is nonetheless charitable although the benefits are not limited to the poor". Scott, *op. cit.* sec. 372, p. 2895.

[18] *Commissioner* v. *Battle Creek, Inc.*, 126 F.2d 405 (5 Cir. 1972); *Davis Hospital, Inc.*, 4 CCH Tax. Ct. Memo. 312 (1945); *Inter-City Hospital Association v.* Squire, 56 F.Supp. 472 (W.D. Wash. 1944)' *Goldsby King Memorial,* 3 CCH Tax. Ct. Memo. 693 (1944); *Lorain Avenue Clinic,* 31 T.C. 141 (1958); *Robert C. Olney,* 17 CCH Tax Ct. Mem. 982 (1958); *Sonora Community Hospital,* 46 T.C. 519 (1966), *aff'd per curiam,* 397 F.2d 814 (9 Cir. 1968).

"charitable" status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary society.

In the field of health care, the changes have been dramatic. Hospitals in the early part of this nation's history were almshouses supported by philanthropy and serving almost exclusively the sick poor.[19] Today, hospitals are the primary community health facility for both rich and poor. Philanthropy accounts for only a minute percentage of the hospital's total operating costs.[20] Those costs have soared in recent years as constant modernization of equipment and facilities is necessitated by the advances in medical science and technology.[21] The institution of Medicare and

[19] As noted by one commentator:

"General hospitals were established in the United States as early as the 18th century to serve the sick, poor and offer a roof and bed for the homeless or for those whose homes were inadequate. These institutions were primarily the last resort of the sick. Their standards of care did not approach those for the simplest custodial care today." John H. Hayes, ed., *Financing Hospital Care in the United States*, Vol. I. "Factors Affecting the Cost of Hospital Care" (1954), p. 9.

[20] Professor William Thomas speaking before a special Senate subcommittee in 1965 stated:

"The image of a voluntary institution as a charitable organization, financing its care of patients to a substantial degree through philanthropy . . . is largely anachronistic. Philanthropy, through increasing, has not been able to match the redoubled demands for health care." *Hearings on Conditions and Problems of the Nation's Nursing Homes*. Subcommittee on Long Term Care, Spec. Committee on Aging, U.S. Senate, 89th Cong., 1st Sess., Pt. 2 (Feb. 15, 1965), p. 559.

[21] "Hospital expenses per patient day have increased over 700% since 1946, rising especially rapidly the last several years. . . . Among factors contributing to the rise in hospital expense are technological changes, increased demand, and rising costs of labor and supplies. . . . The public also demands more—a large number of more costly services—from the hospital now than it did two decades ago because of rising income, increasing insurance coverage, and changing demongraphic charactersitics of the population." *Basic Facts on the Health Industry*. Committee on Ways and Means, 91st Cong., 1st Sess., June 28, 1971, p. 52.

Medicaid in the last decade combined with the rapid growth of medical and hospital insurance has greatly reduced the number of poor people requiring free or below cost hospital services. Much of that decrease has been realized since the promulgation of Revenue Ruling 56-185. Moreover, increasingly counties and other political subdivisions are providing nonemergency hospitalization and medical care for those unable to pay.[22] Thus, it appears that the rationale upon which the limited definition of "charitable" was predicated has largely disappeared.[23] To continue to base the "charitable" status of a hospital strictly on the relief it provides for the poor fails to account for these major changes in the area of health care.

[22] The Supreme Court, in holding unconstitutional a state statute requiring a year's residence in a county as a condition to an indigent receiving nonemergency hospitalization or medical care at the county's expense, referred to the "astronomical costs of hospitalization which bear so heavily on the resources of most Americans" and the fact that the "financial pressures under which private nonprofit hospitals operate have already led many of them to turn away patients who cannot pay or to severely limit the number of indigents they will admit". *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250, 265 (1974).

[23] The state courts have recognized these changes in the health care field. As stated by the Supreme Court of Nebraska in *Evangelical Lutheran Good Samaritan Society* v. *County of Gage*, 181 Neb. 831, 151 N.W.2d 446, 449 (1967):

> "Formerly all institutions furnishing services of this nature, including hospitals and nursing homes, were providing care for many patients without compensation and extended charity in the sense of alms-giving or free services to the poor. With the advent of present day social security and welfare programs, this type of charity is not often found because assistance is available to the poor under these programs. Yet, *** the courts have defined 'charity' to be something more than mere alms-giving or the relief of poverty and distress, and have given it a significance broad enough to include practical enterprises for the good of humanity operated at a moderate cost to those who receive the benefits."

In holding Revenue Ruling 69-545 void, the district court placed undue emphasis on the fact that Congress in 1969 failed to amend the Internal Revenue Code by including language which would have conformed the Code to the new ruling. The Senate Finance Committee in deleting a House provision which would have allowed exempt status to institutions "organized and operated exclusively for the proviind of hospital care" stated:

> "The committee deleted from the bill those provisions which would have conformed the code to the result reached by the 1969 ruling. The committee decided to reexamine this matter in connection with pending legislation on Medicare and Medicaid." [24]

This action or inaction by Congress cannot be interpreted as disapproving the new ruling. Congress could have rejected the ruling had it determined that it was not in conformity with the Code. Instead, it committed the matter for further study in the light of Medicare and Medicaid. No further action has been taken by Congress since the ruling became effective in 1969.

It is important to note also that Revenue Ruling 69-545 rather than overruling Revenue Ruling 56-185 simply provides an alternative method whereby a nonprofit hospital can qualify as a tax exempt charitable organization. That method entails the operation of an emergency room open to all regardless of their ability to pay and providing hospital services to those able to pay the cost either directly or through third party reimbursement. Thus,

[24] Actually the provision of the House bill which was deleted provided a broader exemption than Revenue Ruling 69-545. It would have afforded exempt status to all nonprofit hospitals. Ruling 69-545 requires the operation of an emergency room open to all regardless of ability to pay as well as acceptance of Medicare and Medicaid patients and patients whose hospital costs will be paid by third parties.

to qualify as a tax exempt charitable organization, a hospital must still provide services to indigents.

The required provision of emergency room services is of great import to the indigent. Emergency room service is often the only means of access that the poor have to medical care.[25] Furthermore, the fact that hospitals seeking to qualify as charities pursuant to Revenue Ruling 69-545 must accept Medicare and Medicaid patients is also significant. A large percentage of the indigent populace of the nation is now covered by either Medicare or Medicaid. In the final analysis, Revenue Ruling 69-545 may be of greater benefit to the poor than its predecessor Ruling 56-185.[26] Certainly Ruling 69-545 is more in conformity with the concept of "charitable" as defined in the Treasury Regulation adopted, after extensive study, in 1959 and interpreting § 501 (c) (3).

[25] Finding a physician and getting health care is particularly difficult for families who change communities. A significant portion of these are poor. When health needs become critical, families that do not have adequate financial resources may find the emergency rooms and outpatient clinics of general hospitals the only available resource. These families, along with poor families, who often have no other alternative, have contributed to the 150 million emergency room and outpatient visits in 1967, an increase of 250% during the past two decades." *National Advisory Commission on Health Facilities: A Report of the President* (1969), p. 20.

[26] Moreover, Revenue Ruling 69-545 sets forth a more definite and specific standard. Under Revenue Ruling 56-185 hospitals were required to provide free care only to the extent of their financial ability. Hospitals operating at a deficit would have no obligation under Ruling 56-185. In addition the Ruling qualified the "financial ability" standard by providing:

"The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability . . . . It may also set aside earnings which it uses for improvements and additions to hospital facilities. . . . A nominal charity record for a given period of time, in the absence of charitable demands of the community, will not affect its right to continued exemption."

In summary, we conclude that Revenue Ruling 69-545 is founded on a permissible definition of the term "charitable" and is not contrary to any express Congressional intent.

IV. NOTICE AND HEARING REQUIREMENTS OF APA; ABUSE AND DISCRETION

Appellees contend that, if this court should find that the Commissioner was authorized to promulgate Revenue Ruling 69-545, the district court must nevertheless be sustained because appellants had the legal obligation under 5 U.S.C. § 553 to afford appellees an opportunity to be heard.[27] They argue that Revenue Ruling 69-545 is a substantive rule as opposed to an interpretative ruling and therefore § 553 of the APA is applicable.

Section 553 of the Administrative Procedure Act expressly excepts interpretative rules from the notice and hearing requirements of the Act. This court distinguished interpretative and substantive rules in *Gibson Wine Co.* v. *Snyder*, 194 F.2d 329 (1952):

> "Generally speaking, it seems to be established that 'regulations', 'substantive rules' or 'legislative rules' are those which create law, usually implementary to an existing law; whereas interpretative rules are statements as to what the administrative officer thinks the statute or regulation means. . . . 'A substantive rule is one which . . . is intended to implement the statutory structure or the statutory powers of any agency. An interpretative rule is one which does not have

[27] Having determined that the Revenue Ruling conflicted with Congressional intent, the district court did not reach appellees' contentions that the Ruling was promulgated without proper notice and hearing and constituted an abuse of discretion.

> the full force and effect of a substantive rule but which is in the form of an explanation of particular terms in an Act. If you had an expression in a statute such as 'Interurban Railway,' the query might come up as to what is an 'interurban railway'. A particular agency may adopt a rule defining an interurban railway. That, in a sense, may be called an interpretative rule.' " *Id.* at 331-332.[28]

Here the Commissioner interpreted the meaning of the term "charitable" in § 501 (c) (3). The fact that the term had been interpreted by the Commissioner differently in an earlier revenue ruling is not controlling. In the meantime Treasury Regulations containing a broader concept of "charitable" had been adopted in 1959, after notice and public hearings. In our opinion Internal Revenue 69-545 conforms to the definition of "charitable" set forth in these Regulations. Furthermore, appellants concede that Revenue Ruling 69-545 has no independent binding effect and that the courts are not bound by it unless they choose to accept it as a proper interpretation of the meaning of the word "charitable" as used in § 501 (c) (3).[29] We conclude that Revenue Ruling 69-545 is an interpretative ruling and is not subject to the requirements of § 553 of the APA.[30]

[28] *Accord, United States* v. *353 Cases, etc.*, 247 F.2d 473, 480 (8 Cir. 1957).

[29] *See, American President Lines, Ltd.* v. *Federal Maritime Commission*, 316 F.2d 419, 421-422 and n. 5 (D.C. Cir. 1963).

[30] Appellees lay great stress on the facts that (1) Revenue Ruling 69-545 has a substantial impact on the availability of hospital services for the poor; (2) the I.R.S. is not an expert in health care delivery problems and thus needs to be educated; and (3) the Ruling constitutes a reversal of longstanding I.R.S. policy. While these factors have been considered by the courts with respect to whether notice and hearing are required by the APA, they are not determinative here where a ruling is clearly interpretative in nature and has no legally binding effect.

Appellees finally contend that the promulgation of Revenue Ruling 69-545 constituted an abuse of discretion and should be set aside pursuant to U.S.C. 706(2)(A.)[1] Appellees argue that the Internal Revenue Service acted without considering all of the relevant factors. Their primary attack is again levelled at an alleged failure of the I.R.S. to consider the needs of the poor.

We cannot agree. On its face, Revenue Ruling 69-545 indicates that the interests of the poor were considered. Emergency room treatment for all and acceptance of third-party reimbursement of hospital expenses were specifically established as conditions for tax exempt status under the Ruling. As indicated previously, both of those requirements substantially benefit the poor. Furthermore, the I.R.S. had before it a treasury regulation, 1.501 (c) (3)-1 (d) (2) *supra*, which expressly provided a broad definition of the term "charitable". In light of these factors and the changed health care situation in the country as a result of Medicare, Medicaid and other government programs, of which the I.R.S. was cognizant, the promulgation of Revenue Ruling 69-545 cannot be held to constitute an "abuse of discretion".

Reversed.

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[1] 5 U.S.C. § 706 (2) (A) authorizes courts to set aside agency actions found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law".

WRIGHT, *Circuit Judge, concurring in part and dissenting in part:* I concur in Part II of the court's opinion affirming the District Court on the jurisdictional issues raised on this appeal. On the merits I would also affirm the District Court for the reasons stated in its opinion holding Revenue Ruling 69-545 invalid. *See Eastern Kentucky Welfare Rights Organization* v. *Shultz*, D.D.C., 370 F.Supp. 325 (1973).

Assuming the defendants had the legal right to eliminate the requirement that nonprofit hospitals serve indigents in order to be eligible for "charitable" tax status under the Code, I would still find Revenue Ruling 69-545 invalid because it was issued without compliance with the informal rule-making procedures required by Section 553 of the Administrative Procedure Act, 5 U.S.C. § 553 (1970). Revenue Ruling 69-545 replaced Revenue Ruling 56-185 which provided that a hospital could qualify for tax exempt status only if it was "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." Revenue Ruling 69-545 provided "Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost." Thus Revenue Ruling 69-545 worked a substantial change in the availability of hospital services for the poor. Yet, admittedly, neither the poor nor anyone else was given notice of the proposed change or allowed to comment on it.

The Internal Revenue Service is not expert in health care delivery needs and, consequently was unable to draw on any expertise of its own in determining to free "charitable" hospitals from their obligations under existing IRS rulings to serve the poor. Comment from disciplines more directly related to health care and poverty could doubtless have assisted the IRS in deciding whether to relax the obligations of these hospitals to the poor. In proceeding

without complying with the requirements of the Administrative Procedure Act, the IRS denied itself access to education which would have allowed it to make a more informed judgment. "Section 553 was enacted to give the public an opportunity to participate in the rule-making process. It also enables the agency promulgating the rule to educate itself before establishing rules and procedures which have a substantial impact on those regulated." *Texaco, Inc.* v. *FPC*, 3 Cir., 412 F.2d 740, 743 (1969).

APPENDIX D

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*

Plaintiffs

v.

GEORGE P. SHULTZ, *et al.*

Defendants

Civil Action No. 1378-71

Decided December 20, 1973

Marilyn G. Rose, Jeffrey B. Schwartz, Lauren H. Silver, Anthony Z. Roisman, Thomas Place, Peter Axelrod, Ralph Abascal, Jay-Allen Eisen and Ray Ratliff, Attorneys for Plaintiffs.

John J. McCarthy, Donald Gavin, Milan D. Karlan and Harold H. Titus, Jr., United States Attorney of Counsel, Attorneys for Defendants.

Before: Barrington D. Parker
District Judge

MEMORANDUM OPINION

In this class action against the Secretary of the Treasury and the Commissioner of Internal Revenue declaratory and injunctive relief is sought by the plaintiffs, comprising various health and welfare organizations and several private citizens, all alleging indigency and an inability to pay for hospital services. Called into question is the validity of an Internal Revenue Service (IRS or Service) policy, implemented by a revenue ruling, allowing private nonprofit hospitals to qualify as "charitable" institutions under the Internal Revenue Code of 1954 (Code) without requiring them to admit and provide free or reduced rate services to

persons unable to pay. Jurisdiction of this action lies under 28 U.S.C. §§ 1331, 1340 and 1361; 28 U.S.C. §§ 2201 and 2202, and; 5 U.S.C. §§ 702 and 703.

Plaintiffs seek a declaratory judgment that the defendants have acted unlawfully in granting tax exempt status to private nonprofit hospitals as "charitable" institutions under the Code and not requiring them to admit and provide free services to indigents. They also seek an injunction prohibiting the IRS from granting or continuing to extend tax benefits to such hospitals; to compel defendants to revoke their tax exempt status and to revoke the revenue ruling.[1]

The defendants initially moved to dismiss the complaint on the grounds that: the "Federal taxes" exemption to the Declaratory Judgment Act prevents the grant of such relief; the plaintiffs lack standing to sue; the issuance of revenue rulings may not be reviewed; the doctrine of sovereign immunity bars the suit, and, the ruling was interpretive in nature, therefore rendering the Administrative Procedure Act, 5 U.S.C. § 553 (APA), inapplicable. The motion was denied without opinion.

The matter is now presented on the plaintiffs' motion for summary judgment and the defendants' cross motion for summary judgment. The Court having considered the memoranda of points and authorities of the parties, the supporting affidavits, and the argument of counsel denies the defendants' motion and enters summary judgment on behalf of the plaintiffs.

[1] Plaintiffs also seek to compel the IRS to collect all taxes due and owing because of applications of this allegedly illegal program.

THE STATUTORY BACKGROUND

Section 501(a) and (c) (3)[2] of the Internal Revenue Code grants tax exempt status to charitable organizations; § 170 (a) to (c)[3] permits individual and corporate donors to deduct from their income tax returns contributions to certain en-

[2] The pertinent provisions of § 501 read as follows:

(a) Exemption from taxation.—An organization described in subsection (c) or (d) or section 401(a) shall be exempt from taxation under this subtitle unless such exemption is denied under section 502, 503, or 504 . . .

(c) List of exemption organizations.—The following organizations are referred to in subsection (a): . . .

(3) Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and which does not participate in, or intervene, in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office.

[3] Section 170, dealing with deductions by taxpayers of Charitable contributions, in pertinent part states:

§ 170. Charitable, etc., contributions and gifts

(a) Allowance of deduction.

(1) General rule.—There shall be allowed as a deduction any charitable contributions (as defined in subsection (c)) payment of which is made within the taxable year. A charitable contribution shall be allowable as a deduction only if verified under regulations prescribed by the Secretary or his delegate . . .

(c) Charitable contribution defined.—For purposes of this section, the term "charitable contribution" means a contribution or gift to or for the use of . . .

(2) A corporation, trust, or community chest, fund, or foundation . . .

(B) organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes or for prevention of cruelty to children or animals . . . .

tities organized and operated for charitable purposes. Hospitals as such have never been specifically listed in either §§ 501 or 170 as institutions to be accorded favorable tax consideration and they were able to do so only by qualifying as "charities" under the Code. Under § 7805 (a) of the Code the Commissioner of Internal Revenue is empowered to promulgate necessary rules and regulations to implement the statute. These rulings set forth the official policy of the Service and are designed to guide taxpayers, the interested public and IRS officials in tax matters.[4]

Earlier IRS policy, as expressed in Revenue Ruling 56-185 which complemented § 501, provided in substance that hospitals could qualify as charities upon showing that, in addition to satisfying the other requirements of § 501, and even though permitted to assess full charges to patients capable of paying, they did not refuse treatment to indigent patients.[5] The current position of IRS which gives rise to

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[4] *See* Footnote 9, *infra*.

[5] The portions of Revenue Ruling 56-185 most relevant to this suit are:

In order for a hospital to establish that it is exempt as a public charitable organization within the contemplation of section 501(c)(3), it must, among other things, show that it meets the following general requirements . . .

It must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.

this litigation is represented by Revenue Ruling 69-545 (Ruling). The striking feature of the 1969 ruling is the removal of that condition:

"Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost."[6]

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[6] The pertinent provisions of Revenue Ruling 69-545 are:

Section 501 (c)(3) of the Code provides for exemption from Federal income tax of organizations organized and operated exclusively for charitable, scientific, or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual . . .

To qualify for exemption from Federal income tax under section 501(c) (3) of the Code, a nonprofit hospital must be organized and operated exclusively in furtherance of some purpose considered "charitable" in the generally accepted legal sense of that term, and the hospital may not be operated, directly or indirectly, for the benefit of private interests.

In the general law of charity, the promotion of health is considered to be a charitable purpose. Restatement (Second), Trusts, sec. 368 and sec. 372; IV Scott on Trusts (3rd ed. 1967), sec. 368 and sec. 372. A non-profit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose. If it meets the other requirements of section 501 (c) (3) of the Code, it will qualify for exemption from Federal income tax under section 501 (a) . . .

Revenue Ruling 56-185, C.B. 1956-1, 202, sets forth requirements for exemption of hospitals under section 501 (c) (3) more restrictive than those contained in this Revenue Ruling with respect to caring for patients without charge or at rates below cost. In addition, the fourth requirement of Revenue Ruling 56-185 is ambiguous in that it can be read as implying that the possibility of "shareholders" or "members" sharing in the assets of a hospital upon its dissolution

Allegedly suffering detrimental effects from the Ruling, plaintiffs have leveled what can be fairly categorized as a two-pronged attack upon its validity. They assert that the promulgation of the Ruling was an *ultra vires* act in that it constituted an improper administrative alteration of Internal Revenue Code provisions, in contradiction of long standing tax policy and judicial interpretation. Alternatively, assuming *arguendo* that the defendants could have validly effectuated such a substantive change, they assert that the failure to grant them and other interested parties the opportunities to express their views, as required by the APA and the Fifth Amendment to the Constitution, demands that the ruling be vacated and its policy abandoned.

The defendants on the other hand contend first, that the plaintiffs lack standing to sue and fail to demonstrate a sufficient nexus between the action complained of and any alleged resulting injuries, and second, that the contested promulgation is outside the scope of judicial review. As to the merits, the Service maintains that the Ruling is rationally based and must be upheld.

STANDING

Under § 10 of the APA, 5 U.S.C. § 702, "[a] person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of

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[6] (continued)

will not preclude exemption of the hospital as a charity described in section 501 (c) (3) of the Code. Section 1.501 (c) (3) 1 (b) (4) of the regulations promulgated subsequent to Revenue Ruling 56-185 makes it clear, however, that an absolute dedication of assets to charity is a precondition to exemption under section 501 (c)(3) of the Code.

Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost. Furthermore, requirements four has been modified by section 1.501 (c) (3)-1(b)(4) of the regulations.

a relevant statute, is entitled to judicial review thereof." This provision has been most recently interpreted in *United States* v. *Student Challenging Regulatory Agency Procedures* (SCRAP), ____ U.S. ____, 37 L.Ed. 2d 254 (1973). In that proceeding plaintiff organization, comprised of four law students, challenged the propriety of an Interstate Commerce Commission decision regarding an increase in railroad freight rates without having first prepared and considered an environmental impact statement in accordance with the National Environmental Policy Act. The Supreme Court found that the requirements of § 10 of the APA were satisfied by the litigants' allegations that the agency action would have adverse economic, recreational, environmental and aesthetic effects upon its individual members. In its ruling the Court reaffirmed and expounded upon *Sierra Club* v. *Morton*, 405 U.S. 727 (1972), which established that a person could meet the APA standing requirements only when "the challenged action had caused them 'injury in fact,' and where the alleged injury was to an interest 'arguably within the zone of interests to be protected or regulated' by the statutes that the agencies were claimed to have violated." 405 U.S. at 733. By way of clarification, the *SCRAP* Court ruled that "[a] plaintiff must allege that he has been or will in fact be perceptively harmed by challenged agency action, not that he can imagine circumstances in which he could be affected by the agency's action." ____U.S. ____, 37 L.Ed 2d at 279.[7]

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[7] As the Court noted, SCRAP's alleged injury was not, at first blush, easily demonstrable. It was alleged that the proposed rate increase would step up the use of nonrecyclable products thus requiring more natural resources to be expended from the Washington, D.C. area, where the litigants resided. This was enough, however, to overcome the court's skepticism of entertaining suits in which the pleadings were no more "than an ingenious academic exercise in the conceivable." __ U.S. __, 27 L.Ed. 2d at 270.

It was significantly noted that APA standing is not restricted to those who have been "significantly" affected by agency action. __ U.S. __, 37 L.Ed. 270-71, n. 14.

Plaintiffs, therefore, are confronted with a dual threshold test requiring of them a satisfactory demonstration that on basis of the pleadings first, they were injured as a result of the agency action, referred to as "injury in fact," and second, any such injury was to an interest protected by the law allegedly violated by the administrative action.

INJURY IN FACT

This Court has little difficulty in finding that under the *SCRAP* guidelines the plaintiffs have adequately demonstrated sufficient injury flowing from the issuance of Revenue Ruling 69-545 to afford them their day in Court.

Prior to that Ruling the policy of the Service, in a very real sense, conferred a congnizable interest to indigents by requiring hospitals seeking tax advantages under the Code to give them special consideration. It simply defies common sense to contend that the plaintiffs have remained, or will remain, unaffected by a decision which all but strips from them basic and substantial benefits which had been previously nurtured by the government. Plaintiffs and other individuals have supplied affidavits[8] recounting incidents subsequent to the present Ruling where they were denied needed hospital attention because of indigency by institutions benefiting from the applicable Code provisions and Ruling.

The government points out, and the Court is not unmindful of the fact, that plaintiffs are hard pressed to demonstrate indisputably that their inability to secure medical services was a direct consequence of the Ruling. The circumstances surrounding this litigation, however,

[8] *See* e.g., the following affidavits, filed on April 10, 1973; Eula Hall, Chairman, Health Committee, Eastern Kentucky Welfare Rights Organization; Lards Collins; Carolyn Block; Howard Linville, Treasurer, Association of Disabled Miners and Widows, Inc; Rosezella Cook; Monica Hunter.

suggest that the defendant's view of standing may be far too restrictive and unrealistic. It is obvious that while the poignant representations in the plaintiffs' affidavits do indeed reveal the severe health care crisis confronting the nation's poor, iron-clad documentation of a nexus between their tragic situation and hospital behavior towards indigents, as affected by the new Ruling, has not been and, in all probability, cannot be provided to the satisfaction of the criteria urged by the government. That observation notwithstanding, in light of the crucial significance with which hospitals regard their status as charities,[9] the Court does not consider itself engaged in wild speculation by assuming or recognizing that the relaxation of the requirements for charitable classification would necessarily effect hospital policy, in this case care for indigents, upon which such a status had been earlier dependent.[10]

[9] Considering the statement of John Alexander McMahon, President of the American Hospital Association on Tax Reform, Before the House Committee on Ways and Means, April 13, 1973, submitted as exhibit to Plaintiff's Motion for Summary Judgment. Mr. McMahon stated:

> "Voluntary non profit hospitals are, in varying degrees, dependent upon charitable contributions . . . ."

See also, "American United", Inc. v. Walters, 477 F.2d 1169 (D.C. Cir. 1969) in which the court recognized the importance of tax benefits to "charitable" organizations:

> "Because of the 'tax breaks' attendant to contributions to corporations qualifying under § 170(c) of the Code, qualification thereunder is a precious possession and removal from the Cumulative List, Organizations Described in Section 170(c) of the Internal Revenue Code of 1954 is a damaging—sometimes fatal—injury to the financial status of any 'charitable' organization." 477 F. 2d at 1177.

[10] This analysis is supported by the very purposes for the promulgation of Revenue Rulings. In an analysis of IRS procedure, a former Chief Counsel of the Service explained that the Rulings program, consisting of letters rulings (narrowly drawn to a particular set of facts) and the more general Revenue Rulings, is designed "to provide for certainty as to the tax consequences of contemplated trans-

The Court finds the correlation between agency action and injury to plaintiffs to be at least as demonstrable as that which was accepted by the *SCRAP* Court and accordingly concludes that the initial "injury in fact" requirement under the APA has been met.

INJURY TO A PROTECTED INTEREST

Satisfaction of the standing test further requires that these plaintiffs show that any "injury in fact" has also affected an interest protected under the Internal Revenue Code.

The government argues that the hospitals are the sole intended beneficiaries of the "charitable" Code provisions, claiming that the plaintiffs are "once removed" from the effects of the Code thereby leaving them outside the sphere of any interests ostensibly served by the relevant sections. This argument is too simplistic.

A review of the judicial and legislative background surrounding tax treatment for charities, as made applicable to hospitals in particular, demonstrates the weakness of their position and that plaintiffs do indeed fall within the zone of interests protected by the Code.

The prior Revenue Ruling, 56-185, represented a codification of previous Code interpretations which had been accepted and approved by the courts. In an earlier 1942 case, *Commissioner of Internal Revenue* v. *Battle Creek*, 216 F.2d 405 (5th Cir. 1942), it was held that a

[10] (continued)
actions . . . ." Rogovin, The Four R's: Regulations, Rulings, Reliance and Retroactivity A View From Within, 43 Taxes, 757, 763 (1965). These Rulings, according to Rogovin, have had a "broad impact on our national economy and on proper and reasonable tax administration." Rogovin, *supra* at 764.

It is clear that the IRS fully expects that policy promulgated by way of Revenue Rulings will effect the taxpaying public. It may be assumed, therefore, that activities relating to one's tax position will necessarily be influenced by such IRS rulings.

sanitarium could properly be classified as a charitable institution under an earlier edition of the Revenue Code. As the court there explained at 406:

> "[i]t is also usual for hospitals and sanitariums to charge those able to pay for service rendered, in order to pay the expenses of the institution, while not denying treatment to others unable to pay anything. Such institutions are classed as charitable."

Intercity Hospital Association v. *Squire*, 56 F. Supp. 472 (W.D. Wash. 1944) involved the question of whether or not two hospitals were eligible for charitable treatment. The court ruled for the hospitals involved, placing significant emphasis upon the fact that "an extremely liberal rule prevailed concerning admittance of patients without funds."

This policy continued to receive favorable judicial recognition after it had been officially promulgated by the IRS in Revenue Ruling 56-185. A decision of the Tax Court in *Sonora Community Hospital*, 46 T.C. 519 (1966), denied tax exempt status: "the mere fact that petitioner maintained a hospital does not in and of itself justify the conclusion that it was operated exclusively for charitable purposes." 46 T.C. at 525. In *Lorraine Avenue Clinic*, 31 T.C. 141 (1958), an insubstantial showing of aid to the poor proved fatal to the clinic's claim of being a charitable organization.[11]

[11] *See also* 47 ALR 3d 1191 (1971) for an analysis of tax exempt organizations. The following observation was made with regard to hospitals:

> "It is a usual practice for a hospital to charge patients who are able to pay for the services rendered in order to maintain the institution, pay off the indebtedness on its buildings, expand its facilities, or improve its services, while not denying treatment and care to patients who are unable to pay anything." 37 ALR 3d at 1223.

The annotation then surveyed numerous court rulings, both state and federal, which clearly revealed that charitable status, in the great

Congressional developments are also significant. In 1924 the Senate considered amending the "charitable" provisions of the then existing tax laws to enable health service organizations to automatically qualify for the relevant tax considerations. This proposal was not warmly received and was eventually abandoned.[12]

The matter was most recently weighed in connection within the 1969 tax reform measures which included an attempt to confer hospitals with tax exempt status without regard to indigent service. The House version of the Tax Reform Act of 1969, H.R. 13270, which carried such a revision, was purportedly proposed to alleviate the "significant uncertainty as to the content to which a hospital must accept patients who are unable to pay, in order to retain its exempt status." H.Rep. No. 413 91st Cong., 1st Sess. 43 (1969).[13] This explanation, made public on

[11] (continued)
majority of cases, depended upon the hospital showing to varying quantitative degrees, that indigent patients had been admitted and treated. 37 ALR 3d pp. 1223-1234.

[12] A proposed change to a House Bill, (H.R. 6715) under consideration by the Senate was introduced to allow for the automatic qualification of health organizations as charities. The amendment appears in parentheses:

> Any corporation, or community chest, fund, or foundation, organized and operated exclusively for religous, charitable (including preventive and constructive service for relief, rehabilitation, health, character building, and citizenship), scientific, literary, or educational purposes, etc. 65 Cong. Rec. 8171 (1924).

This attempt was prompted by a ruling of the Commissioner of Internal Revenue, II-2-1128, I.T. 1800, Int. Rev. Bull.—1.2 (1923), which required relief to the poor as a condition for charitable status. The amendment was withdrawn by its sponsor, Senator Willis. 65 Cong. Rec. 8173.

[13] H.R. 13270, 91st Cong. 1st Sess. authorized that "Section 501(c)(3) (relating to the definition of exempt organizations) is amended by inserting after 'animals', the phrase', or for the providing of hospital care,'."

August 4, 1969 by the Committee on Ways and Means, preceded by approximately two months the October 8, 1969 promulgation of Revenue Ruling 69-545. Shortly thereafter, on November 21, 1969, the Senate Committee on Finance acknowledged the new Ruling but explained why the Senate Bill would *not* incorporate this revision:

> "The Internal Revenue Service has, however, issued a ruling on October 8, 1969, indicating that hospitals, if they meet all the other requirements of § 501(c) (3), are exempt under that provision, whether or not they provide charitable services on a non-cost or low-cost basis . . . . The Committee deleted from the bill those provisions which would have conformed the Code to the result reached by the 1969 Ruling. The committee decided to reexamine this matter in connection with pending legislation on Medicare and Medicaid." S. Rep. No. 91-552, 91st Cong. 1st Sess. 61 (1969).[14]

[11] (continued)
Hospitals had actively endorsed and advocated the passage of that revision. Julius M. Greisman, Attorney for the American Hospital Association, testifying before the House Committee on Ways and Means, felt that Revenue Ruling 56-185 was difficult to administer and urged that

> ". . . the tax law should be amended to provide that any hospital is exempt so long as it is operated principally for the purpose of providing hospital care."

Hearings on Tax Reform Act of 1969, H.R. 13270 Before the House Committee on Ways and Means, 91st Cong. 1st Sess. 1425.

[14] The Senate Committee on Finance, in a Report of the Staff on Medicare and Medicaid, Problems, Issues and Alternatives, considered in early 1970 the substance of Revenue Ruling 69-545. The staff noted that prior to the Ruling, IRS policy had provided a measure of protection against any unreasonable refusal by a nonprofit hospital to provide charitable and below-cost care:

> "The staff strongly recommends revocation of Revenue Ruling 60-545 in light of the recent legislative history and continuation of the prior position of the Service until such

The Senate version, as indicated by the above cited report, omitted the proposed House change. The House Conference Committee subsequently acquiesced in this determination:

> "The House Bill provides that hospitals, if they meet all the other requirements of Section 501 (a) (3), are exempt under that provision, whether or not they provide charitable services on a non-cost or low-cost basis. The Senate amendment strikes out these provisions. The conference substitute . . . follows the Senate amendments." H. Rep. No. 91-782. 91st Cong., 1st Sess. 289-90 (1969).

The Tax Reform Act of 1969 contained no revisions on the subject.

This analysis, cursory as it may be, sufficiently highlights the point that Congress and the judiciary have consistently insisted that the application of §§ 501 and 170 to hospitals be conditioned upon a demonstration that ameliorative consideration be given poor people in need of hospitalization. The Court cannot accept the government's conclusion that these Code provisions are in no way intended to aid plaintiffs and those similarly situated. To do so one would have to disregard what has been held to be the underlying rationale for allowing charitable deduction. See *e.g. McGlotten* v. *Connally*, 338 F. Supp. 448, 456 (D.D.C. 1972), which declared unconstitutional tax advantages granted to a fraternal order which denied membership to non-white applicants. Chief Judge Bazelon, writing for a Three-Judge District Court, appropriately noted:

[14] (continued)

> time as Congress can devise an alternative approach establishing reasonable yardsticks of charitable service related to the financial capacity of a hospital. Such action by the Service would assist in protecting the availability of necessary hospital care to Medicare, Medicaid, and other poor patients." Medicare and Medicaid—Problems, Issues, and Alternatives, Report of the Staff to the Committee on Finance, U.S. Senate 91st Cong. 1st. Sess. (Feb. 9, 1973).

> "The rationale for allowing the deduction of charitable contributions has historically been that by doing so, the Government relieves itself of the burden of meeting public needs which in the absence of charitable activity would fall on the shoulders of the Government. 'The Government is compensated for its loss of revenue by its relief from financial burdens which would otherwise have to be met by appropriations from public funds.' H. Rep. No. 1860, 75th Cong. 3rd Sess. 19 (1938)."

Although the above discussion in *McGlotten* focused on § 170 deductions allowed donors, it can hardly be disputed that the granting of tax exempt status to charities, pursuant to § 501 (c) (3), rests upon the same foundation.

In view of the foregoing the Court has no trouble in concluding that plaintiffs have adequately shown that, by reason of Revenue Ruling 69-545, they have suffered injury to an interest cognizable under and protected by the "charitable" provisions of the Internal Revenue Code. The second prong of the *SCRAP* test having thus been satisfied, standing is conferred upon plaintiffs to maintain this suit.

One further observation on the standing issue seems appropriate. As a general rule, Federal court inquiry into the propriety of tax policy stems from "refund" litigation instituted by disgruntled taxpayers. Standing in those cases presents no serious problem. However, in this situation it is quite obvious that since the contested Ruling in every respect establishes criteria quite favorable to persons whose tax status will be affected, its validity could not, in all probability, be tested in that normal course. If the circumstances were reversed, i.e. were the most stringent provisions of Rev. Rul. 56-185 to overrule those of Rev. Rul. 69-545—taxpayers denied deductions and hospitals refused tax exempt status, would be afforded the opportunity of challenging the Ruling upon which that tax liability had been predicated. Indeed, those litigants would be able to

make the very sort of argument plaintiffs in this suit have presented, namely that the Ruling is contrary to statute and therefore without effect. The fact that the administration of Revenue Ruling 69-545 will not produce protesting taxpayers eager to challenge its policy and application should not immunize the Ruling from such a testing where, as shown earlier, the Code policy it purports to serve has a fundamental purpose of aiding and benefiting the class of people to which plaintiffs belong.

The Court is not unmindful of and shares the government's concern for maintaining an efficient tax structure free from potential disruption from challenges by citizens for whom that policy has no actual tax consequence. However, the case *sub judice* presents somewhat of a unique situation in that the tax law in question also bears an identifiable relationship to citizens other than those whose tax returns are immediately affected.

It is also within the context that the Court, following the principles enunciated in *McGlotten* v. *Kennedy, supra* at 452-54, concludes that the "Federal taxes" exemption to the Declaratory Judgment Act, 28 U.S.C. § 2201 and the Tax Injunction Act, 26 U.S.C. § 7421(a) do not bar this suit.[15]

AUTHORITY TO PROMULGATE REVENUE RULING 69-545

As indicated at the outset, the defendants have maintained that the Commissioner's action is not subject to review by this Court, basing this central theme upon the "discretionary action" exception to the APA, 5 U.S.C. § 701(a)(2) which provides that:

[15] In McGlotten, the purposes of the above restrictions on litigation—the smooth and efficient assessment and collection of taxes—were held not to have ben jeopardized by plaintiffs' challenge to the constitutionality of IRS policy.

That reasoning is equally applicable in this suit.

> This chapter applies, according to the provisions thereof, except to the extent that . . . (2) agency action is committed to the agency discretion by law.[16]

The Court, however, finds this provision to be inapplicable.

The Supreme Court has recently held this exception to be " . . . very narrow . . . applicable in those rare instances where 'statutes are drawn in such broad terms that in a given case there is no law to apply.' S. Rep. No. 752, 79th Cong., 1st Sess. 26 (1945)." *Citizens to Preserve Overton Park* v. *Volpe,* 401 U.S. 402, 410 (1971). To be sure, almost every administrative ruling, to some degree, flows from discretionary power vested in the executive branch. But the self-categorization of a decision as being "discretionary" does not of itself preclude court scrutiny under § 701(a)(2). The limited scope of that subsection is further evidenced by § 706 of the APA, titled "Scope of Review," the terms of which empower a reviewing tribunal to vacate administrative determinations for "abuse of discretion." The obvious implication of that provision, as Professor Jaffe has observed, is that agency action is reviewable:" . . . *the presence of discretion should not bar a court from considering a claim of illegal or arbitrary use of discretion.*" L. Jaffe, Judicial Control of Administrative Action, 374-75 (1965) [Emphasis in original].

The *Overton Park* Court keyed the applicability of this exception to whether, under a particular set of circumstances, there is law to be applied by the administrator, *supra,* 401 U.S. 410, 413, and in this vein it is difficult to imagine that the deliberative process from which the policy embodied in Revenue Ruling 69-545 emerged could be properly conducted without at least some consideration and application of the legal principles at-

[16] Subsection (a)(1) makes exception from the general rule allowing for review where "statutes preclude judicial review." The government places no apparent reliance upon this provision.

tendant to the "charitable" sections of Internal Revenue Code. Indeed, the government's insistence that the action was merely interpretative undercuts its position that the Ruling falls within the § 701 (a) (2) exception to review. To interpret is to explain, or to tell the meaning of—when action has the effect of changing or altering the terms of a statue the limits of "interpretation" have been overstepped. Any discretion incorporated into the IRS's authority to promulgate rules and regulations is necessarily limited by the understanding that Congress, not the Treasury, is responsible for the formulation and institution of basic tax policy. It is true, as a matter of jurisprudence and efficient tax administration, that courts have regularly paid deference to the expertise attributed to the IRS in tax related matters and therefore judicial interference has been reluctantly employed. However, this exhibition of restraint is predicated upon the assumption that administrative rulings will do no more than effectuate, implement and clarify the provisions of the Code which have been Congressionally enacted:

> "The power of an administrative officer or board to administer a federal statute and to prescribe rules and regulations to that end is not the power to make law—for no such power can be delegated by Congress—but the power to adopt regulations to carry into effect the will of Congress as expressed by the statute. A regulation which does not do this, but operates to create a rule out of harmony with the statute is a mere nullity." *Manhattan General Equipment Co. v. Commissioner*, 297 U.S. 129, 134 (1936).

See also *Dixon v. United States*, 381 U.S. 68, 74-75 (1965) for a more recent application of this principle. When this assumption is proven wrong, the courts must act to rectify any administrating determination which is not in accord with the Code. The ruling is therefore reviewable.

Section 706 of the APA sets forth the standards for judicial inquiry, obligating " . . . the reviewing court to engage in a substantial inquiry."[17] the initial step of which is to determine whether the administrator "acted within the scope of his authority." *Overton Park, supra* at 415, (citations omitted). The Court turns for guidance to several recent Supreme Court rulings which, although not brought pursuant to the APA, are nonetheless instructive as to the contours of IRS authority.[18]

It is settled law that the positions adopted by the Treasury are presumptively valid and will not ordinarily be interfered with by the courts. *Bingler* v. *Johnson*, 394 U.S. 741, 750-51

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[17] Section 706 provides:

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall—

(1) compel agency action unlawfully withheld or unreasonably delayed; and

(2) hold unlawful and set aside agency action, findings, and conclusions found to be—

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) contrary to constitutional right, power, privilege, or immunity;

(C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

(D) without observance of procedure required by law;

(E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

(F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error. Pub.L. 89-554, Sept. 6, 1966, 80 Stat. 393.

[18] The cases generally followed the refund litigation route, which as earlier indicated, would not be available to these plaintiffs. See pages 11-12, *supra*.

(1969); *United States* v. *Correl*, 389 U.S. 299, 307 (1967).[19] That doctrine, however, is not automatically dispositive. As *United States* v. *Cartwright*, 411 U.S. 546, 550 (1973) admonished, it " . . . is to set the framework for judicial analysis; it does not displace it." The case of *Fribourg Nav. Co.* v. *Commissioner*, 383 U.S. 272 (1966) is particularly well suited to offer an analytical framework and will serve as a platform for this Court's examination.

At issue in Fribourg was the soundness of IRS policy, effectuated by a revenue ruling, concerning the sale of and deductions allowable for depreciable assets. An affected taxpayer litigated the issue to culmination with the Supreme Court declaring in his favor that the IRS position was contrary to the Code and therefore invalid. Although the actual holding is, of course, of no significance to the issues presented in this suit, the approach followed by the Supreme Court is. In reaching its determination, congnizance was taken and great weight was given to the fact that for many years the IRS had followed a fundamentally different policy which had been solidified by court as well as congressional approval.

In *Cartwright*, *supra*, the Supreme Court adopted a similar line of reasoning when it invalidated a treasury regulation in which the criteria for determining the valuation of mutual fund holdings for federal estate tax purposes was established. After carefully noting that regulations are generally upheld, Mr. Justice White proceeded to hold that the regulation in question was an unrealistic and unreasonable interpretation of the Internal Revenue Code. Referring to the Investment Company Act

[19] The Correll Court, in considering a challenge to a rule followed by the Commissioner of the Internal Revenue Service held that: "The role of the judiciary in cases of this sort begins and ends with assuring that the Commissioner's regulations fall within his authority to implement the congressional mandate in some reasonable manner." 389 U.S. at 307.

of 1940, which regulates the mutual funds field, he concluded: "Congress surely could not have intended [the pertinent section of the Code] to be interpreted in such a manner." 411 U.S. at 557.[20]

The reasonableness of Revenue Ruling 69-545, and the policy announced therein, therefore hinges upon whether or not it is in accord with the terms of the Code. As is usually the case, there is no clear cut disparity between the administrative ruling and the statutory language, making it necessary for the Court to discern the intended meaning and proper interpretation of the pertinent provisions. Following *Fribourg*, the Court will focus upon and give careful consideration to the relevant judicial, legislative[21] and administrative history. This provides little, if any, support for the government's position.

The defendants do not dispute that Revenue Ruling 69-545 represented, as did the revenue ruling in *Fribourg*, a clear change of previously administered policy. And the Court does not mean to imply that the Commissioner should be so inflexible as to be required, under all circumstances, to rigidly adhere to past practices. However, he

[20] The Court adopted the position of a dissenting member of the Tax Court which had earlier dealt with the challenge Regulations:

> "It does not follow that, because [the Commission] has a choice of alternatives, his choice should be sustained where the alternative chosen is unrealistic. In such a situation the regulations embodying that choice should be held to be unreasonable." 411 U.S. at 557, quoting from Estate of Wells v. Commissioner, 50 T.C. 871, 878 (1968).

[21] The significance of legislative intent is further conspicuously revealed in Bingler v. Johnson, *supra*. Although the Congressional history concerning the section of the Code there involved (§ 117 exclusions from income of scholarships and fellowships) was by no means crystal clear, the Court nonetheless embarked upon an analysis of the relevant congressional history, determined what it considered to be the legislature's apparent reasoning and finally ruled that the contested Treasury Regulation comported with that meaning.

may not do so without sound basis and authority. As Justice White, in his *Fribourg* dissent, observed:

> "We have frequently in the past recognized the Commissioner's authority to re-evaluate a prior position upon the basis of greater experience and reflection and to adjust that position to the extent that he becomes convinced that an adjustment is necessary *to comport with congressional intent*, even when this results in a distinct reversal of a previous position. . . ." 383 U.S. at 297 (citations omitted; emphasis added).

The government has attempted to justify the reversal of policy as to § 501(c)(3) with reference to Professor Scott's treatise on Tursts as well as the Restatement of Trusts, for which Scott is the Reporter. Rev. Ruling 69-545 itself includes such a reference.[22] Urging that modern day "community benefit" concepts of charity, viewed in conjunction with the importance of promoting general health care, serve as a sufficient and rational basis for the IRS policy,[23] the Ruling is defended as a perfectly permissible interpretative determination. For judicial support reliance is placed upon *Green* v. *Connally*, 330 F. Supp. 1150 (D.D.C. 1971) where Circuit Judge Leventhal, emphasizing federal and public policy considerations, ruled that private educational institutions that followed racially discriminatory practices towards students were precluded from enjoying tax benefits

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[22] "In the general law of charity, the promotion of health is considered to be a charitable purpose. Restatement (Second), Trust, Sec. 368 and Sec. 372; IV Scott on Trusts (3rd Ed. 1967), Sec. 368 and Sec. 372." Rev. Rul. 69-545.

[23] Two aspects of the Ruling have been noted in this regard: 1. that emergency rooms must remain available to *all* patients and 2. that persons who are able to pay by means of third party reimbursement must receive general hospital treatment. These conditions, however, are of no consequence to the Courts findings that the Service erred in effectuating the substantial changes found in the Ruling.

under §§ 501(c)(3) and 170(a) to (c). The defendants take much comfort in the following passage:

> "But clearly, the term 'charitable' is used 'in its generally accepted legal sense,' . . . and not in a street or popular sense (such as, e.g., benevolence to the poor and suffering) . . . . Thus 'strong analogy' can be derived from the general common law of charitable trusts at least for close interpretative questions . . . ." 330 F. Supp. at 1157 (citations omitted).

The emphasis given by the IRS to Scott's principles of trust law, which the Court has no reason to doubt, was misplaced and provides, even when taken in conjunction with *Green*, an insufficient basis, in view of prior legislative and judicial history, to justify the basic shift in policy. The *Green* opinion, which of course followed the Ruling and therefore serves only as an after-the-fact basis, while perhaps pertinent for general definitional considerations, can hardly justify the Commissioner's attempt to reform the Code on an issue which had acquired a significant degree of meaning and rationale of its own. It is unnecessary to repeat in full this background but it is important to emphasize that the Ruling was promulgated simultaneously with a flourish of Congressional activity on the subject, allowing one to conclude that the Service would have naturally looked to Congress for insight. The House Report, which included the controversial change, was proposed on August 4, 1969; Senate rejection came in mid-November; and House adoption of the Senate revision followed shortly thereafter.

It is readily apparent that the Ruling was issued before any *final* Congressional determination had been rendered. Although at the time of promulgation the House had adopted a measure which was supportive of the Ruling, the required Senate approval had not been given. The Senate Finance Committee, which reported on its version, not only

clearly stated that the matter would once again be reviewed in conjunction with Medicare and Medicaid legislation, it also gave some indication that the Committee members thought the Ruling to be in conflict with the Code:

> "The Committee deleted from the bill those provisions which would have conformed the Code to the result reached by the 1969 Ruling." S. Rep. No. 91-552, 91st Cong. 1st Sess. 61 (1969).

The IRS cannot satisfactorily demonstrate, by reason of this legislative activity, that it was supplied with a sufficiently convincing expression of Congressional intent as to warrant implementation of the sweeping policy change embodied in the Ruling.

The defendants claim, however, that Congress, being fully aware of the Ruling and its consequence, granted implied approval by failing to affirmatively reject it. The Court finds this argument unpersuasive. The legislative record, even if viewed in the light most favorable to the government, reveals that the Congress, which was by no means silent on the issue, felt uncertainty and doubt as to the propriety of the Ruling. Nor has the Court been apprised of anything to indicate that the Senate was amenable to the House provisions which it deleted but felt that, in view of the Ruling, any further legislative action would be superfluous.

In short, any reading of the sequence of events to establish Congressional affirmation of the Ruling is less than persuasive and is an unacceptable basis for upholding its validity.

Accordingly, the Court finds that Revenue Ruling 69-545 was improperly promulgated and is without effect inasmuch as it allows private non-profit hospitals to qualify as charities under the Internal Revenue Code of 1954

without requiring the hospitals to offer special financial consideration to persons unable to pay.[24]

In view of the above holding the Court need not reach due process questions presented under the Fifth Amendment and the Administrative Procedure Act.

Counsel for plaintiffs shall present an appropriate order within 10 days.

Barrington D. Parker
United States District Judge

December 20, 1973

[24] The Court recognizes that Revenue Ruling 69-545 makes reference only to § 501 (c)(3) and not to § 170. The Court has assumed, and the government has not argued to the contrary, that since the underlying policy considerations behind the "charitable" provisions of both sections are the same, conditions and requirements of § 501(c)(3) would apply equally to § 170.

APPENDIX E

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EASTERN KENTUCKY WELFARE
RIGHTS ORGANIZATION, et al.
Plaintiffs

v.

GEORGE P. SHULTZ, et al.
Defendants

MEMORANDUM ORDER

On December 20, 1973 the Court filed in this case its Memorandum Opinion. This proceeding, brought by several health and welfare organizations challenged a Revenue Ruling of the Internal Revenue Service. Before entry of the final judgment the American Hospital Association (AHA), through its counsel, sought leave to intervene as *amicus curiae* and in its application requested the Court to reconsider its Opinion. For the reasons set forth below this belated and tardy application to intervene is denied.

The complaint in this proceeding was filed on July 12, 1971, and the Government sought a dismissal on procedural and jurisdictional grounds. After full argument the motion to dismiss was denied on April 28, 1972. Cross motions for summary judgment were then filed by the parties. The issues were fully briefed and argued and on December 20, 1973 the Court entered a Memorandum Opinion finding that:

> "Revenue Ruling 69-545 was improperly promulgated and is without effect inasmuch as it allows private nonprivate hospitals to qualify as charities under the Internal Revenue Code of

> 1954 without requiring the hospitals to offer special financial consideration to persons unable to pay."

Pursuant to the opinion, counsel for the plaintiffs submitted a proposed order. Shortly thereafter counsel for the American Hospital Association, which had not been previously involved in the litigation, advised the Court by a letter dated January 8, 1974 of its concern with the potential effects the Opinion would have upon its member hospitals. He also requested the Court to delay entry of final judgment until the Association had an opportunity to file certain papers. On January 14th the AHA filed a motion, supported by an affidavit of one of its Vice-Presidents, seeking permission to intervene as *amicus curiae* and requesting a "reconsideration" of the Memorandum Opinion.

The untimeliness of the AHA's request as well as its failure to give adequate justification for any delay is most apparent. No claim is made that the AHA did not have full knowledge of the proceedings. Indeed, the affidavit candidly admits that the Association knew of this litigation since 1971 but refrained from intervening until this late date because of a belief and an assumption that procedural and jurisdictional objections interposed by the defendants would prevail and be dispositive. At no time over the course of more than two years did the AHA seek to intervene under the provisions of Rule 24, Federal Rules of Civil Procedure. Although the Government's cross motion for summary judgment revewed the procedural defenses to which the AHA now alludes, the substantative merits were unmistakenly at issue. The reasoning presented by the Association for resting on its oars for more than two years and until after an opinion had been rendered before seeking an appearance is wholly unacceptable.

Although this clear exhibition of laches is alone a sufficient basis for denying the AHA application, the Court

will comment briefly on the Association's position. The representations made in the affidavit attempt to demonstrate that Revenue Ruling 69-545 was of no ascertainable detriment to the class of persons who instituted this suit, and in this regard appear to be most appropriately addressed to the issue of standing. That question was extensively briefed and was given considerable attention. The Court is satisfied, however, with the conclusion it has reached and finds the facts offered by the AHA, even assuming *arguendo* that they are true and uncontroverted, to be insufficient to persuade the Court that plaintiffs failed to meet standing requirements. *United States v. Students Challenging Regulatory Agency Procedures*, 37 L. Ed. 254 (1973) and *Sierra Club* v. *Morton*, 405 U.S. 727 (1972).

Accordingly, it is this 28th day of January, 1974,

ORDERED that the Application of the American Hospital Association To Intervene As Amicus Curiae, be and it is denied.*

Barrington D. Parker
United States District Judge

* In view of this ruling there is no need for the Court to act upon the AHA's motion for reconsideration. It is noted however, that there is considerable doubt as to the propriety of such relief. See City and County of Denver v. Denver Tramway Corporation, 23 F. 2d 287, 295 (8th Cir. 1927).

APPENDIX F

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EASTERN KENTUCKY WELFARE
RIGHTS ORGANIZATION, *et al.*

Plaintiffs

v.

GEORGE P. SHULTZ, *et al.*

Defendants

Civil Action No. 1378-71

ORDER AND JUDGMENT

Plaintiffs and defendants have filed cross-motions for summary judgment concerning the legal obligations of defendants under the Internal Revenue Code with respect to the status, under sections 501(c)(3) and 170(a)-(c) of the Internal Revenue Code of 1954 (Title 26 U.S.C.), of non-profit hospitals which refuse admission and services to persons unable to pay. Having had full opportunity to consider said motions, pleadings, affidavits, and memoranda, and after hearing argument, the Court for the reasons set forth in the Opinion filed on December 20, 1973, determines that there is no material issue of fact in dispute, and expressly directs the entry of a judgment in favor of plaintiffs as follows:

I. DECLARATORY RELIEF

Declared:

1. That the defendants acted outside their scope of authority under the Internal Revenue Code of 1954 (Code) by promulgating Revenue Ruling 69-545 inasmuch as that Ruling removed previously followed requirements, found in

Revenue Ruling 56-185, that private nonprofit hospitals seeking tax exempt status as charitable organizations under §501(c)(3) of the Code must provide free or below cost treatment to individuals unable to pay for such services.

2. That Revenue Ruling 69-545, to the extent that it modifies Revenue Ruling 56-185 with regard to the requirements relating to the caring for patients without charge or at below cost rates, is void and without effect.

II. INJUNCTIVE RELIEF

Ordered, Adjudged and Decreed that defendants enjoined and restrained from:

1. Following the above voided policy contained in Revenue Ruling 69-545;

2. Granting tax exempt status under § 501(c)(3) of the Code and allowing deductions for contributions under § 170(a)-(c) of the Code to private nonprofit hospitals unless and until said hospitals:

a. Satisfy the requirements found in Revenue Ruling 56-185, in particular, that they:

> (1) be operated, to the extent of their financial ability, for those not able to pay for services and not exclusively for those who are able and expected to pay; (2) furnish the above "charitable" services on a reduced rate and below cost or no charge basis; (3) not refuse patients in need of hospital care who cannot pay.

b. Conspicuously post, in appropriate accessible public areas, notice, to be prepared by the defendants and subject to Court approval, which shall include:

(1) That the hospital has applied for or has been granted tax exempt status order § 501(c)(3) of the Code;

(2) An intelligible recitation of the previously mentioned provisions of Revenue Ruling 56-185.

The defendants shall take the necessary and immediate steps to implement this Order, including but not limited to

revoking the voided portion of Revenue Ruling 69-545 and promulgating in its stead appropriate Rulings, and shall report their progress to the Court within 60 days of the entry of this Order, and at such further time as the Court deems necessary.

The Court will retain juridiction over this case during said implementation.

Barrington D. Parker
United District Judge

January 28, 1974

APPENDIX G

PERTINENT PROVISIONS OF STATUTES AND REGULATIONS

26 U.S.C. 501. Exemption from tax on corporations, certain trusts, etc.

(a) Exemption from taxation.—An organization described in subsection (c) . . . shall be exempt from taxation under this subtitle . . . .

(c) List of exempt organizations.—The following organizations are referred to in subsection (a):

> (3) . . . Corporations, and any community chest fund, or foundation, organized and operated exclusively for religious, charitable, scientific testing for public safety, literary or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual. . . .

26 U.S.C. 170. Charitable, etc., contributions and gifts.

(a) Allowance of deduction.—

> (1) General rule.—There shall be allowed a deduction any charitable contribution (as defined in subsection (c)) payment of which is made within the taxable year. A charitable contribution shall be allowable as a deduction only if verified under regulations prescribed by the Secretary of his delegate.

(c) Charitable contribution defined.—For purposes of this section, the term "charitable contribution" means a contribution or gift to or for the use of—

> (2) A corporation, trust, or community chest, fund, or foundation—
>
> (B) organized and operated exclusively for religious, charitable, scientific, literary, or

> educational purposes or for the prevention of cruelty to children or animals. . . .

5 U.S.C. 553. Rule Making.

> (b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—
>
> (1) a statement of the time, place, and nature of public rule making proceedings;
>
> (2) reference to the legal authority under which the rule is proposed; and
>
> (3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.
>
> Except when notice or hearing is required by statute, this subsection does not apply—
>
> (A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or
>
> (B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.
>
> (c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. . .
>
> (d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date. . .
>
> (e) Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.

5 U.S.C. 706. Scope of review.

. . . The reviewing court shall— . . .

(2) hold unlawful and set aside agency action, findings, and conclusions found to be—

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law . . .

26 CFR 1.501(c) (3)-(2) Charitable defined. The term "charitable" is used in section 501(c) (3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions. Such term includes; Relief of the poor and distressed or of the underprivileged; advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human and civil rights secured by law; or (iv) to combat community deterioration and juvenile delinquency. The fact that an organization which is organized and operated for the relief of indigent persons may receive voluntary contributions from the persons intended to be relieved will not necessarily prevent such organization from being exempt as an organization organized and operated exclusively for charitable purposes. . . .

APPENDIX H

26 CFR 1.501(c)-1: Organizations organized and operated for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals.

Examples illustrate whether a nonprofit hospital claiming exemption under section 501(c)(3) of the Code is operated to serve a public rather than a private interest Revenue Ruling 56-185 modified

Rev. Rul. 69-545[1]

Advice has been requested whether the two nonprofit hospitals described below qualify for exemption from Federal income tax under section 501(c) (3) of the Internal Revenue Code of 1954. The articles of organization of both hospitals meet the organizational requirements of section 1.501(c)(3)—1(b) of the Income Tax Regulations, including the limitation of the organizations' purposes to those described in section 501(c)(3) of the Code and the dedication of their assets to such purposes.

Situation 1. Hospital A is a 250-bed community hospital. Its board of trustees is composed of prominent citizens in the community. Medical staff privileges in the hospital are available to all qualified physicians in the area, consistent with the size and nature of its facilities. The hospital has 150 doctors on its active staff and 200 doctors on its courtesy staff. It also owns a medical office building on its premises with space for 60 doctors. Any member of its active medical staff has the privilege of leasing available office space. Rents are set at rates comparable to those of other commercial buildings in the area.

The hospital operates a full time emergency room and no one requiring emergency care is denied treatment. The

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[1] Also released as Technical Information Release 1022, dated Oct. 8, 1969.

hospital otherwise ordinarily limits admissions to those who can pay the cost of their hospitalization either themselves, or through private health insurance, or with the aid of public programs such as Medicare. Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients.

The hospital usually ends each year with an excess of operating receipts over operating disbursements from its hospital operations. Excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training education, and research.

Situation 2. Hospital B is a 60-bed general hospital which was originally owned by five doctors. The owners formed a nonprofit organization and sold their interests in the hospital to the organization at fair market value. The board of trustees of the organization consists of the five doctors their accountant, and their lawyer. The five doctors also comprise the hospital's medical committee and thereby control the selection and the admission of other doctors to the medical staff. During its first five years of operations, only four other doctors have been granted staff privileges at the hospital. The applications of a number of qualified doctors in the community have been rejected.

Hospital admission is restricted to patients of doctors holding staff privileges. Patients of the five original physicians have accounted for a large majority of all hospital admissions over the years. The hospital maintains an emergency room, but on a relatively inactive basis, and primarily for the convenience of the patients of the staff doctors. The local ambulance services have been instructed by the hospital to take emergency cases to other hospitals in the area. The hospital follows the policy of ordinarily limiting admissions to those who can pay the cost of the services rendered. The five doctors comprising the original medical staff have continued to maintain their offices in the

hospital since its sale to the nonprofit organization. The rental paid is less than that of comparable office space in the vicinity. No office space is available for any of the other staff members.

Section 501(c) (3) of the Code provides for exemption from Federal income tax of organizations organized and operated exclusively for charitable, scientific, or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual.

Section 1.501(c)(3)-1(d) (ii) of the regulations provides that an organization is not organized or operated exclusively for any purpose set forth in section 501(c) (3) of the Code unless it serves a public rather than a private interest.

Section 1.501(c) (3)-1(d)(2) of the regulations states that the term "charitable" is used in section 501(c)(3) of the Code in its generally accepted legal sense.

To qualify for exemption from Federal income tax under section 501(c)(3) of the Code, a nonprofit hospital must be organized and operated exclusively in furtherance of some purpose considered "charitable" in the generally accepted legal sense of that term, and the hospital may not be operated, directly or indirectly, for the benefit of private interests.

In the general law of charity, the promotion of health is considered to be a charitable purpose. *Restatement (Second), Trusts,* sec. 368 and sec. 372; IV *Scott on Trusts* (3rd ed. 1967), sec. 368 and sec. 372. A nonprofit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose. If it meets the other requirements of section 501(c)(3) of the Code, it will quality for exemption from Federal income tax under section 501(a).72

Since the purpose and activity of Hospital 4, apart from its related educational and research activities and purposes, are providing hospital care on a nonprofit basis for members or its community, it is organized and operated in furtherance of a purpose considered "charitable" in the generally accepted legal sense of that term. The promotion of health, like the relief of poverty and the advancement of education and religion , is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community. *Restatement (Second), Trusts,* sec. 368, comment (b) and sec. 372, comments (b) and (c); IV *Scott on Trusts* (3rd ed. 1967), sec. 368 and sec. 372.2. By operating an emergency room open to all persons and is proving hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, Hospital A is promoting the health of a class of persons that is broad enough to benefit the community.

The fact that Hospital A operates at an annual surplus of receipts over disbursements does not preclude its exemption. By using its surplus funds to improve the quality of patient care, expand its facilities, and advance its medical training, education, and research programs, the hospital is operating in furtherance of its exempt purposes.

Furthermore, Hospital A is operated to serve a public rather than a private interest. Control of the hospital rests with its board of trustees, which is composed of independent civic leaders. The hospital maintains an open medical staff, with privileges available to all qualified physicians. Members of its active medical staff have the privilege of leasing available space in its medical bulding. See Rev. Rul. 69-464, page 132, this Bulletin.) It operates an active and generally accessible emergency room. These

factors indicate that the use and control of Hospital A are for the benefit of the public and that no part of the income of the organization is inuring to the benefit of any private individual nor is any private interest being served.

Accordingly, it is held that Hospital A is exempt from Federal income tax under section 501(c)(3) of the Code.

Hospital B is also providing hospital care. However, in order to qualify under section 501(c)(3) of the Code, an organization must be organized and operated *exclusively* for one or more of the purposes set forth in that section. Hospital B was initially established as a proprietary institution operated for the benefit of its owners. Although its ownership has been transferred to a nonprofit organization, the hospital has continued to operate for the private benefit of its original owners who exercise control over the hospital through the board of trustees and the medical committee. They have used their control to restrict the number of doctors admitted to the medical staff, to enter into favorable rental agreements with the hospital, and to limit emergency room care and hospital admission substantially to their own patients. These facts indicate that the hospital is operated for the private benefit of its original owners, rather than for the exclusive benefit of the public. See *Sonora Community Hospital* v. *Commissioner,* 46 T.C. 519 (1966), aff'd. 397 F.2d 814 (1968).

Accordingly, it is held that Hospital B does not qualify for exemption from Federal income tax under section 501 (c)(3) of the Code. In considering whether a nonprofit hospital claiming such exemption is operated to serve a private benefit, the Service will weigh all of the relevant facts and circumstances in each case. The absence of particular factors set forth above or the presence of other factors will not necessarily be determinative.

Even though an organization considers itself within the scope of *Situation* 1 of this Revenue Ruling it must file an application on Form 1023, Exemption Application, in order to be recognized by the Service as exempt under section

501(c)(3) of the Code. The application should be filed with the District Director of Internal Revenue for the district in which is located the principal place of business or pincipal office of the organization. See section 1.501(a)—1 of the regulations.

Revenue Ruling 56-185, C.B. 1956-1, 202, sets forth requirements for exemption of hospitals under section 501(c)(3) more restrictive than those contained in this Revenue Ruling with respect to caring for patients without charge or at rates below cost. In addition, the fourth requirement of Revenue Ruling 56-185 is ambiguous in that it can be read as implying that the possibility of "shareholders" or "members" sharing in the assets of a hospital upon its dissolution will not preclude exemption of the hospital as a charity described in section 501(c)(3) of the Code. Section 1.501(c)(3)—1(b)(4) of the regulations promulgated subsequent to Revenue Ruling 56-185 makes it clear, however, that an absolute dedication of assets to charity is a precondition to exemption under section 501(c)(3) of the Code.

Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost. Furthermore, requirement four has been modified by section 1.501(c)(3)—1(b)(4) of the regulations.

APPENDIX I

Rev. Rul. 56-185

Criteria or tests to be met in determining whether a hospital qualifies for exemption from Federal income tax under section 501(a) of the Internal Revenue Code of 1954 as an organization described in section 501(c)(3) thereof.

Advice has been requested concerning the criteria or tests to be met in determining whether a hospital can qualify for exemption for income tax as a public charitable organization.

Section 501(c) of the Internal Revenue Code of 1954 describes certain organizations exempt from income tax under section 501(a) and reads, in part, as follows:

> (3) Corporations, and any community chest, fund or foundation, organized and operated exclusively for religious, charitable, scientific***purposes,***and no part of the net earnings of which inures to the benefit of any private shareholder or individual, and no substantial part to the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office.

The only ground upon which a hospital may be held to be exempt under section 501(c)(3) of the Code is that it is organized and operated primarily for educational, scientific or public charitable purposes. Usually, the ground for exemption is that it is organized and operated for public charitable purposes. The Supreme Court of the United States in *Hendering* v. *Sanda D. Dallas, Et al,* 203 U.S. 144, Ct.D. 884, C.B.XIII-2.191 (1938), held that the provisions of law granting exemption of income devoted to charity are

organizations of the law in the taxpayer's favor, where language for motives of public policy, and are not to be narrowly construed. Thus, in regard to hospital and similar organizations, the Internal Revenue Service takes the position that the term "charitable" in its legal sense and as it is used in section 501(c)(3) of the Code contemplates an implied public trust constitued for some public benefit, the income or beneifical interest of which may not inure to the benefit of any private shareholder or individual.

In order for a hospital to establish that it is exempt as a public charitable organization within the contemplation of section 501(c)(3), it must, among other things, show that it meets the following general requirements:

1. It must be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick. A nonprofit hospital chartered only in general terms as a charitable corporation can meet the test as being organized exclusively for charitable purposes. See *Commissioner* v. *Battle Creek, Inc.* 126 Fed. (2d) 405).

2. It must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.

3. It must not restrict the use of its facilities to a particular group of physicians and surgeons, such as a medical partnership or association, to the exclusion of all other qualified doctors. Such limitation on the use of hospital facilities is inconsistent with the public service concept inherent in section 501(c)(3) and the prohibition against the inurement or benefits to private shareholders or individuals. It is recognized, however, that in the operation of a hospital there must of necessity be some discretionary authority in the management to approve the qualifications of those applying for the use of the medical facilities. The size and nature of facilities may also make it necessary to impose limitations on the extent to which they may be made available to all reputable and competent physicians in the area.

4. Its net earnings must not inure directly or indirectly to the benefit of any private shareholder or individual. This includes the use by or benefit to its members of its earnings by way of a distribution of profits, the payment of excessive rents or excessive salaries, or the use of its facilities to serve their private interests. If provision is made in the bylaws for dividends, exemption will not be allowed even though no dividends have been declared. Exemption will not be defeated, however, merely because the shareholders or members might possibly at some future date share in the assets upon dissolution in the absence of a case of mala fides where there appears to be a plan on the part of the shareholder or individual to acquire assets on the dissolution of the corporation.

A community hospital of the type supported partly by contributions from the general public and/or public grants from a city, county or state, normally meets the requirements of section 501(c)(3) as a public charitable organization. It is formed for the purpose of furnishing hospital facilities to all persons in the community at the lowest possible cost and necessarily accepts patients who are unable to pay for hospital facilities in order to retain the support of the community. A nominal charity record for a

given period of time in the absence of charitable demands of the community, will not affect its right to continued exemption. On the other hand, a hospital formed by one or more physicians in a community who may own the capital stock thereof or rent the hospital facilities to a corporation which they control requires careful study to determine whether it is being operated in part to serve their interest, directly or indirectly. See I.T. 2421, C.B. VII-2, 150 (1928).

A hospital formed to operate on a membership basis to provide, at fixed rates, prepaid hospitalization to its members is not a charitable organization within the meaning of section 501(c)(3) of the Code. Compare G.C.M. 22554, C.B. 1940—1,243. But exemption will not be denied merely because the hospital maintains a prepayment plan, so long as such plan is available to all persons living in the area and so long as the hospital makes available its facilities to the indigent as well as to pay patients to the same extent as any other hospital not operated for profit.

A hospital which is organized as required by section 501(c)(3) of the Code, but which engages primarily in operations foreign to its stated purposes, cannot qualify as a charitable organization under the section. Conversely, a hospital, otherwise exempt, will not lose its exempt status by reason of engaging in operations unrelated to its stated purposes if such operations may be considered as merely incidental. Such a hospital will, however, be required to file an income tax return, Form 990—T.U.S. Exempt Organization Business Income Tax Return, if its gross income (included in computing unrelated business taxable income) for the taxable year is $1,000 or more.

APPENDIX J

INCOME LEVELS FOR ELIGIBILITY FOR MEDICAID BY STATE (FAMILIES OF FOUR)

STATE	Must be covered[1]	May also cover Additional Families[2]
ALABAMA	1488	No
ALASKA	4800	No
ARIZONA	None[3]	No
ARKANSAS	1500	No
CALIFORNIA	3732	Yes
COLORADO	3144	No
CONNECTICUT	3984	Yes
DELAWARE	2760	No

[1] These figures are annualized, from the largest amount that can be paid to a family of four, each month, by State, as of July 1974 in the aid to families with dependent children program, a category which must be covered by a State participating in the Medicaid program (42 U.S.C. 1396a(a)(10)(A)). Public Assistance Statistics, September 1974, National Center for Social Statistics, Social and Rehabilitation Service, U.S. Department of H.E.W., DHEW Pub. No. (SRS) 75-031000, NCSS Report A-2(9/74).

[2] A State at its option may include in the Federal-State medicaid program, families with incomes which do not exceed 133% of the level which would make them eligible for the aid to dependent children program. (42 U.S.C. 1396a(a)(10)(C) and 1396b(f)(1)(B)(i)). The States with the "no" notation are those which include none. The States with the "yes" notation include some, which in most instances includes persons only slightly above the aid to dependent children level rather than the full 133% . Source: Division of Planning & Evaluation, Medical Services Administration, Income and Resources Levels for Medically Needy in Title XIX, Plans in Operations as of December 31, 1974.

[3] Arizona has never participated in the Medicaid program. In October 1975 it shall commence participation. As of July 1974 a family of four, to be eligible for public assistance, could have income not exceeding $2,208 a year.

STATE	Must be covered[1]	May also cover Additional Families[2]
DISTRICT OF COLUMBIA	3348	Yes
FLORIDA	1812	No
GEORGIA	1920	No
HAWAII	4788	Yes
IDAHO	3576	No
ILLINOIS	3456	Yes
INDIANA	3000	No
IOWA	3552	No
KANSAS	3984	Yes
KENTUCKY	2052	Yes
LOUISIANA	1464	No
MAINE	2016	No
MARYLAND	2712	Yes
MASSACHUSETTS	3648	Yes
MICHIGAN	4800	Yes
MINNESOTA	4440	Yes
MISSISSIPPI	720	No
MISSOURI	2196	No
MONTANA	3288	Yes
NEBRASKA	3360	Yes
NEVADA	2412	No
NEW HAMPSHIRE	4152	Yes
NEW JERSEY	4272	No
NEW MEXICO	2472	No
NEW YORK	4704	Yes
NORTH CAROLINA	2208	Yes
NORTH DAKOTA	3780	Yes
OHIO	2412	No
OKLAHOMA	2832	Yes
OREGON	4056	No
PUERTO RICO	636	Yes
RHODE ISLAND	3732	Yes
SOUTH CAROLINA	1404	No
SOUTH DAKOTA	3936	No

STATE	Must be covered[1]	May also cover Additional Families[2]
TENNESSEE	1584	Yes
TEXAS	1680	No
UTAH	3288	Yes
VERMONT	4320	Yes
VIRGIN ISLANDS	1992	Yes
VIRGINIA	3732	Yes
WASHINGTON	4032	Yes
WEST VIRGINIA	2604	Yes
WISCONSIN	4836	Yes
WYOMING	2724	No

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Supreme Court of the United States

October Term, 1974

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,

Petitioners,

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *et al.*,

Respondents.

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION

In Opposition to Petition for Writ of Certiorari

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WILLIAM E. SIMON,
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Respondents.

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION
In Opposition to Petition for Writ of Certiorari

INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION

This Brief is presented in opposition to the Petition for Writ of Certiorari filed on behalf of Eastern Kentucky Welfare Rights Organizations, et al. (hereinafter "petitioners"), and is directed solely to the substantive issues presented in Reasons 3, 4 and 5 of said Petition. Counsel for both petitioners and respondents have consented to the American Hospital Association's filing of the instant Brief *amicus curiae*.

The American Hospital Association (hereinafter "AHA") is an association whose membership includes

more than 3000 voluntary non-profit hospitals. The interest of AHA in this case arises from the fact that these hospitals are the organizations whose charitable status forms the underlying issue in this case and whose tax-exempt status is determined alternatively under *Revenue Ruling 56-185*, 1956-1 *Cum. Bull.* 202 and *Revenue Ruling 69-545*, 1969-2 *Cum. Bull.* 117. Petitioners are seeking to have the criteria for exemption in the latter ruling declared invalid.

AHA sympathizes with petitioners' concern with adequate health care for the poor. However AHA believes that *Revenue Ruling 69-545*, upheld in the decision below as an alternative criterion for exemption, is correct and will provide more effective access to hospital care for indigent persons than the uncertain, inadministrable and superannuated free care standard advanced by petitioners.

SUMMARY OF ARGUMENT

The underlying issue in this case is the validity of *Revenue Ruling 69-545*. Petitioners' substantive position appears to be that *Revenue Ruling 69-545* is invalid because it allegedly eliminates the requirement that non-profit hospitals must provide "free" care for indigents as a condition to qualifying for tax-exempt status.

AHA respectfully submits that, contrary to petitioners' contention, the instant case does not present an important question of Federal law which should be decided by this Court because *Revenue Ruling 69-545* does not constitute a departure from established Federal policies on health care for the indigent. Both the Ruling and the decision below are consonant with the existing Federal policy of financing hospital care for the poor through reimbursement, as exemplified by Medicare and Medicaid, rather

than of requiring hospitals to provide free, unreimbursed care. Further, the imminent enactment of National Health Insurance with universal coverage will render petitioners' issues moot. Therefore, the issues presented by petitioners are political questions which properly should be, and in fact are being, resolved in the legislative arena.

AHA also respectfully submits that, contrary to petitioners' contention, the decisions of the Court of Appeals for the District of Columbia is not in conflict with decisions of other circuits. No other circuit has ruled on the validity of *Revenue Ruling 69-545* or on the rendition of free care as the sole criterion for tax exemption.

ARGUMENT

I. THERE IS NO IMPORTANT FEDERAL QUESTION FOR THIS COURT TO DECIDE.

A. Tax Exempt Hospitals Must Still Provide Services to Indigents.

The promulgation of *Revenue Ruling 69-545* has not eliminated the requirement for tax exemption of non-profit hospitals that special financial consideration be given to those unable to pay. *Revenue Ruling 69-545* does not supersede *Revenue Ruling 56-185*,[1] but instead provides an alternative method for non-profit hospitals to provide health care for the poor and thereby qualify for exemption. This alternative method requires operation of an emergency room open to all regardless of ability to pay[2] and

[1] This ruling requires, as one of its four criteria, that a tax exempt hospital must be operated to the "extent of its financial ability" for those unable to pay.

[2] The emergency room is usually the principal point of access to hospital care for the poor. As one commentator has noted: "[T]he ambulatory care facilities [i.e., emergency services] of the urban general hospital constitute a major medical care resource for the economically deprived, 'core city', minority population groups." *Medical Care in Transition, American Journal of Public Health*, 414 (1966).

prohibits discrimination against Medicare or Medicaid patients.[3]

Revenue Ruling 69-545 and the decision below provide the poor with more concrete assistance than the vague and subjective "extent of financial ability" standard of *Revenue Ruling* 56-185[4]. Thus, petitioners' assertion that the Ruling and the decision below upholding its validity adversely affect the health care of some 20-40 million poor persons is without substance.

B. The Decision Below Is Not in Conflict with Federal Health Policy.

Petitioners' contention that the decision below is in conflict with a Federal health policy which imposes an obligation on non-profit hospitals to provide free care for the poor is inaccurate. No such Federal policy exists.

The Federal government has long recognized the importance of adequate health care for each individual. However, Federal policy is directed toward achieving this goal by providing reimbursement for health services for persons unable to pay, rather than by imposing an obligation upon health care providers to supply free care. Medicare and Medicaid (42 U.S.C. §1395-1396) provide the clearest and most significant expression of this Federal policy of reimbursement, rather than free care.

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[3] Because hospitals often receive less than actual cost for Medicaid patients, the prohibition against discrimination toward Medicaid patients is a significant benefit to the poor. *See* Idaho Corp. of Benedictine Sisters v. Marks, Civ. No. 1-72-169 (D. Idaho, filed Aug. 29, 1973).

[4] As stated by the District of Columbia Circuit: "Thus, to qualify as a tax-exempt charitable organization, a hospital must still provide services to indigents . . . In the final analysis, *Revenue Ruling* 69-545 may be of greater benefit to the poor than its predecessor Ruling 56-185." Petitioners' App. at 26a-27a.

The various legislative proposals for National Health Insurance introduced during the 93rd and 94th Congress further illustrate the Federal reimbursement policy. None of these bills contain any obligation on the part of hospitals to provide free care. They do, however, recognize that the Federal government should guarantee adequate health care for all by assuming the cost of health insurance for those unable to pay.[5]

As evidence of an alleged Federal free care policy, petitioners refer to the obligation to provide indigent care imposed upon recipients of construction grants under the Hill-Burton program and its successor, the National Health Planning and Resources Development Act of 1974 (collectively the "Hill-Burton Program"). However, rather than being evidence of petitioners' free care policy, the Hill-Burton Program is in effect a further example of Federal reimbursement policy. As under Medicare and Medicaid, the Federal government is really purchasing services for the poor, although under the Hill-Burton Program payments are made in advance of, rather than subsequent to, the rendition of services.[6]

In any event, grants made under the Hill-Burton Program represent only a small part of the government's overall health program. A comparison of (1) government expenditures for reimbursement to health care providers

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[5] During 1974, extensive hearings were held by the House Committee on Ways and Means on National Health Insurance and numerous bills providing for such legislation were introduced during the 93rd Congress. The highlights of these bills are set forth in the Appendix attached hereto. The major proposals, H. R. 1, 94th Cong. 1st Sess. (1975) (the Ullman Bill) and S. 3, 94th Cong. 1st Sess. (1975) (the Kennedy-Griffiths Bill), have been reintroduced in the 94th Congress.

[6] This obligation to provide a reasonable volume of services to persons unable to pay has been held to be a contractural obligation arising out of the receipt of Federal funds under the Hill-Burton Program. Euresti v. Stenner, 458 F.2d 1115 (10th Cir. 1972).

under Medicare and Medicaid to (2) amounts expended under the Hill-Burton Program evidences an overwhelming commitment to a Federal reimbursement policy. For example, in 1974 the Federal government spent *125 times more on reimbursement* for health services than it spent on grants under the Hill-Burton Program.[7]

C. The Enactment of National Health Insurance Will Render the Issues Moot.

The imminent enactment of National Health Insurance further illustrates the inappropriateness of the issues petitioners are seeking this Court to review. All major proposals for National Health Insurance provide universal coverage enabling all Americans to obtain health care when required regardless of ability to pay. Public statements by Congressional leaders indicate that passage of some form of National Health Insurance will occur during the 94th Congress.[8]

The enactment of National Health Insurance legislation will completely moot the issues raised by petitioners.

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[7] In 1974 government spent $11,321,900,000 on Medicare payments and $11,218,400,000 on Medicaid payments, for a total expenditure of $22,540,300,000. Worthington, *National Health Expenditures: 1929-1974*, SOCIAL SECURITY BULL. Table 3 (1975). On the other hand, government appropriations for hospital facilities construction under Hill-Burton Programs during 1974 were only $120,000,000. *U.S. Dept. of H.E.W., Public Health Services, Health Facilities Construction: By Type of Funds (1920-1974) (Hill-Burton Federal Grants).*

[8] Ways and Means Chairman Al Ullman (D. Calif.) has recently predicted that: "This has to be the year for national health insurance." 5 NATIONAL HEALTH INSURANCE REPORTS, No. 3 (1975); WASHINGTON REPORT ON MEDICINE & HEALTH, No. 1442 (Feb. 17, 1975). *See* to the same effect, statements of Sen. Russell Long (D. La.), Chairman of the Senate Finance Committee, and Hon. Dan Rostenkowski (D. Ill.), Chairman of the Ways and Means Sub-Committee on Health reported in WASHINGTON REPORT ON MEDICINE AND HEALTH, No. 1442 (Feb. 17, 1975).

Under such a program all persons would be covered by health insurance, and thus the need for any free care would be eliminated.

D. Petitioners' Multiplicity Argument Is Without Merit.

No multiplicity of lawsuits will result if the Court denies certiorari in this case. In the first place, the enactment of National Health Insurance will prevent proliferation of litigation on the issues presented herein. Although petitioners assert that "unemployment with its consequential loss of health insurance coverage" will exacerbate the need for free care and encourage further litigation, the expected passage of the Emergency Health Insurance Extension Act[9] to benefit unemployed workers should avoid such result.

In the second place, the commencement of the two lawsuits cited by petitioners in the 5½ years since the publication of Revenue Ruling 69-545 would hardly indicate an opening of the flood gates.[10] The dearth of litigation against the more than 3,000 tax exempt hospitals casts serious doubt upon petitioners' claim as to the importance of the issues presented and prediction of an anticipated multiplicity of lawsuits. Moreover, a decision on the merits herein would not resolve the issues raised in the two cases cited by petitioners.[11]

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[9] H.R. 5000, 94th Congress, First Session.

[10] Petitioners' Petition at 18 n. 15. Lugo, et al. v. Simon, et al., Civ. 74-345, N.D. Ohio; Chapman, et al. v. Berkshire Medical Center, et al., Civ. 74-1954F, D. Mass.

[11] The outcome of these cases would remain unresolved because the question of whether defendant hospitals are operating "to the extent of their financial ability" for those unable to pay under the alternate test of *Revenue Ruling 56-185* would be unaffected by a decision herein.

II. THERE IS NO CONFLICT.

A. There Is No Conflict of Decisions Between Circuits.

Petitioners assert that the decision below "conflicts with the principles set forth in every federal and tax court decision on the subject decided since 1942." Petitioners apparently are not contending, and indeed cannot in good faith contend, that the decision below is "in conflict with the decision of another court of appeals on the same matter." There are no Federal decisions, except the reversed District Court decision below, which have held that Ruling invalid.

B. There Is No Conflict in Established Principles.

Unable to assert a direct conflict between circuits, petitioners attempt to extrapolate a conflict argument by asserting a conflict between the principles underlying the decision below and general principles enunciated in other decisions. This assertion is incorrect.

1. The Lower Court Decision Does Not Eliminate Indigent Care.

The decision below does not depart from prior case law requiring tax exempt hospitals to give special financial consideration to the poor. As indicated above, the decision below properly recognizes that *Revenue Ruling 69-545* provides meaningful criteria for insuring responsiveness to the needs of the poor. The requirements for providing emergency room care to all regardless of ability to pay and accepting Medicare and Medicaid patients are not only compatible with the concern for the poor expressed in existing case law, but provide more concrete assistance to them than the vague and subjective "extent of financial

ability" standard of *Revenue Ruling 56-185* or the "special financial consideration" rule enunciated by the District Court below.

2. The Definition Of Charity Encompasses Social And Economic Change.

The term "charitable" as used in section 501 (c) (3) of the Internal Revenue Code of 1954, 26 U.S.C. §501(c) (3), must be interpreted in its generally accepted legal sense.[12] A basic principle in the law of charity is that ". . . the differing condition, character and wants of communities and nations, change and enlarge the scope of charity, and where new necessities are created, new charitable uses must be established.[13]

By placing reliance on cases decided between 1942 and 1945, petitioners have ignored the existence of major changes in the delivery of health care in the United States, which must be taken into consideration in formulating criteria for tax exemption of today's hospitals.[14] However,

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[12] Treas. Reg. §1.501 (c) (3)-1(d) (2) (1959); Green v. Connolly, 330 F.Supp. 1150, 1157, 1158-59 (D. D.C.), *aff'd per curiam sub nom.* Coit v. Green, 404 U.S. 997 (1971); Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337 (D.C. Cir. 1932).

[13] Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 46 F.2d 855, 865 (7th Cir. 1931); Green v. Connolly, 330 F.Supp. 1150, 1158-59 (D.C. Cir. 1971); BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 369 (2d Ed. 1964).

[14] In 1940, out of a civilian population of 131,669,000, approximately 12,312,000 persons, or 9.4% of the population were covered by some form of health insurance. U.S. BUREAU OF CENSUS, DEPT. OF COMMERCE, CURRENT POPULATION REPORTS, Series P-60, No. 81; SOURCE BOOK OF HEALTH INSURANCE 1971, at 16. (Health Insurance Inst., N.Y. 1971). However, by 1971, out of a civilian population of 201,000,000, approximately 188,513,000 persons or 92% of the population were covered by some form of health insurance. SOURCE BOOK OF HEALTH INSURANCE 1972-1973 at 17-20. (Health Insurance Inst. N.Y. 1973). Persons eligible for Medicaid are not included in these statistics and, therefore, a substantial percentage of the portion of those listed as not covered were actually provided with protection.

the Court of Appeals for the District of Columbia rejected petitioners' attempt to render the law of charity stagnant by concluding that the means by which a tax exempt hospital serves the poor is not immutable, but must be varied to conform to important economic and social changes in the financing of health care and in government policy.

3. Other Cases Dealing With Private Benefit Are Distinguishable.

Although petitioners cite a number of cases purportedly standing for the rule that the rendition of free care is the *sine qua non* for tax exemption of non-profit hospitals, the actual issue in each of those cases was whether hospitals were operated for the private benefit of a limited number of individuals.[15] A basic principle in the law of charity is that in determining exempt status the test is not whether the patients of a hospital pay more or less for their services, but whether those charged with its operations are conducting it for their private profit or advantage.[16] The absence of a program for charitable care may be strong evidence of the existence of private benefit,[17] but no Federal case has ever denied exemption exclusively on the grounds that a non-profit hospital, which is free of the

[15] Section 501(c)(3) limits charitable exemption to organizations, "no part of the net earnings of which inure to the benefit of any private shareholder or individuals . . ." *See also* Treas. Reg. §1.501(c)(3)-1(d)(1)(ii) 1959.

[16] IV A. Scott, The Law of Trusts §372.1 (3d Ed. 1967); Bogert, The Law of Trusts and Trustees (2d Ed. 1964); 15 Am. Jur. 2d *Charities* §148.

[17] Harding Hospital v. United States, 505 F.2d 1068 (6th Cir. 1974); Sonora Community Hospital, 46 T.C. 519 (1966) aff'd per curiam, 397 F.2d 814 (9th Cir. 1968); Lorain Avenue Clinic, 31 T.C. 141 (1958).

taint of private profit, did not render enough free care to qualify under section 501(c)(3).[18]

Petitioners' attempt to construct a conflict in decision is thus unavailing. There is no conflict between circuits, either directly or in principle. Further, *Revenue Ruling 69-545*, rather than being in conflict with prior decisions and earlier rulings, is compatible with them by conforming the criteria for charitable exemption to social policy and economic changes in the financing of health care for the poor.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that the Petitioner for Writ of Certiorari should be denied.

Respectfully submitted,

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[18] In Comm'r v. Battle Creek, 126 F.2d 405 (5th Cir. 1942), cited by petitioners as in conflict with the lower court decision, the issue adjudicated was whether an organization incorporated under the General Corporation Laws of Florida, rather than under Non-profit Organization Laws, and authorized to conduct any lawful business, could qualify under the "organizational test" of section 501(c)(3).

APPENDIX

Reproduction of Appendix A from Comparative Analysis of Four Major National Health Insurance Plans Before the 93rd Congress, Prepared by the Interreligious Task Force on Health Care, June, 1974.

(Attached)

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Appendix A—Major National Health Insurance Plans

	National Health Care Services Reorganization and Financing Act H.R. 1 Ullman	The Health Security Act S. 3 H.R. 22 Kennedy Griffiths Corman
CONSUMER PARTICIPATION	"Equitable" consumer representation on health care corporation boards as well as on the national and state advisory councils.	Provision for consumers in an advisory capacity in policy development and administration of program. Appointed at national, state, local levels.
COMPREHENSIVE COVERAGE	Up to 90 days of hospital care; 10 visits to a doctor per year; 80% of cost of ancillary services, appliances, ambulances, up to 90 days in a nursing home; drugs; up to 45 days in hospital for mental illness, alcoholism or drug abuse, preventive care checkups, well-baby care; dentistry to age 7, vision services to age 12; home health.	Nearly the whole range of personal health care services. All hospital and doctor bills, ancillary services (such as X-ray, lab tests, drugs provided in the HMO); up to 120 days in a skilled nursing home, up to 45 days in hospital for mental illness, medical appliances (eyeglasses, hearing aids, artificial limbs, pacemakers, etc.); ambulances, dentistry for children under 15 years; some outpatient psychiatric care; vision services; some drugs.
POSITIVE HEALTH CONCEPT	Health care corporations—community-based, non-profit organizations capable of providing comprehensive health services in a given geographic area—HCC's charged with health education of membership.	Health Maintenance Organizations (HMO's) required to furnish or arrange for all covered services except mental health and dental services. Emphasis on preventive medicine, early diagnosis of illness, and medical rehabilitation.
FINANCING: **Trust Fund;** **Progressive Tax Based on Ability to Pay;** **No Deductibles**	Payroll taxes and general tax revenues pay for care for aged; general revenues pay for care for the poor. Employer and employees share premiums for group plans on 75-25 basis. Deductibles: $2 per doctor visit; $5 per day for hospital care; $2.50 a day for nursing home care; 20% cost of ancillary services, appliances and most other covered items; $1 per drug prescription. Advisory Council directed to give consideration of national trust fund to supply supplemental capital.	Establishes health security trust fund. Fifty percent of funds from: 1) a 3.5% tax on employers' payroll; 2) a 1% tax on employees' wages and on unearned income up to $15,000 a year; 3) a 2.5% on self-employed income up to $15,000 a year. The other fifty percent from federal general revenues. No deductibles.
ACCESS TO HEALTH CARE AS EVERY PERSON'S RIGHT	A new federal Department of Health would contract with insurance companies and non-profit HCC's for medical services to the poor and aged. Insurance for others under group and individual private plans would have to meet standards set by bill. State health commissions established.	Explicitly stated. All residents of the United States would be eligible for benefits. A new federal agency, the Health Security Board and National Health Security Advisory Council will administer the program and replace all private health insurance plans.
PROVISION FOR QUALITY CARE	Department of Health prescribed quality standards; state health commission regulates peer review systems.	Establishes a commission on the quality of health care, which would develop and enforce national standards for participation both by individual and institutional providers.
PERSONNEL DEVELOPMENT/ DEPLOYMENT: **Manpower** **Research** **Facilities**	Secretary of Department of Health shall make a continuing study.	Would actively encourage more efficient organization of existing health manpower and would provide funds for special training of health professionals and allied personnel. Establishes a resources development fund. Establishment of regional and health services areas.

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Appendix A--Major National Health Insurance Plans(Con'td.)

	Medicredit S. 444 H.R. 2222 HANSEN BROYHILL FULTON	Comprehensive National Health Insurance Act S. 3286 H.R. 3870 KENNEDY MILLS
CONSUMER PARTICIPATION	None—only two representatives of the general public on a National Health Insurance Advisory Board of 11 members.	"Advisory" Councils established; only one of which has a required majority of consumers. All utilization review controlled by providers or medical societies.
COMPREHENSIVE COVERAGE	Hospital bills for 60 days; 80¢ of doctor bills, ancillary services, home health care, ambulances, dentistry for children ages 2-6; 120 days of skilled nursing home care; preventive care and checkups; well-baby care.	*Unlimited*—in-patient hospital and physician services, medical and and other health services. *Limited*—home health services (100 visits per year), post-hospital extended care (100 days per year), out-patient drugs and biologicals (specific chronic conditions only), mental health services (30 days), and preventive care for most children's services.
POSITIVE HEALTH CONCEPT	No positive health concept.	Very little positive health in this bill. Preventive care for children's vision, dental and hearing check-ups. Pre-natal, well baby care and family planning services. All other care is episodic in nature and intent.
FINANCING: **Trust Fund;** **Progressive Tax Based on Ability to Pay;** **No Deductibles**	Trust fund created for those with no federal income tax liability; insurance premium for everyone else under 65. Deductibles: $50 toward each hospital or nursing home stay; 20¢ of the cost of the doctor bill and other covered services.	National Health Insurance Trust Fund to be established from: 1) a 1¢ tax on employees' wages; 2) a 3¢ tax on employers' payroll; 3) a 2½¢ tax on unearned income. *Deductibles*: $150.00 per year-limit of 2 per family. *Co-insurance*: 25¢ on all covered services past the deductible. Out-patient drug co-insurance is $1.00 per prescription. *Limit*: $1,000.00 per year. Built in protection for low income persons. $6.00 premium for long-term care—paid from benefits.
ACCESS TO HEALTH CARE AS EVERY PERSON'S RIGHT	Access to insurance aim of program. The government would set voluntary minimum standards for private health insurance plans. Those who purchase insurance meeting standards would get tax credits on federal income tax ranging from 10 to 90¢ of the premium, depending on income. Those too poor to pay income tax would get governmental voucher to pay for their insurance.	No person being exempt from the 1¢ tax on earned income would tend to give an equality of participation that is unfortunately threatened by the co-insurance and deductible charges. Graduate students with no earned income and non-resident aliens would not be covered.
PROVISION FOR QUALITY CARE	Peer review by local medical societies only mechanism.	Quality management payments to providers who keep their dollar rate lower than average. PSRO's only other provision for quality control.
PERSONNEL DEVELOPMENT/ DEPLOYMENT: **Manpower** **Research** **Facilities**	No funds—at national level a Health Insurance Advisory Board would determine policy and regulations in relation to carriers of insurance	Health Resources Development Board established with authority to contract for tests and demonstrations. Work closely with state or regional comprehensive health planning agencies (still on congressional drawing board).

Appendix A—Major National Health Insurance Plans(Con'td.)

	Catastrophic Health Insurance and Medical Assistance Reform Act S. 2513 LONG RIBICOFF	Comprehensive Health Insurance Plan H.R. 12684 S. 2970 MILLS SCHNEEBELI PACKWOOD
CONSUMER PARTICIPATION	None	None.
COMPREHENSIVE COVERAGE	Title I: Focus on catastrophic coverage. Same as medicare parts A & B except there is no upper limit on hospital days or home health visits. Title II: Basic health insurance coverage applies to low income persons only. Eligibility is based on income (Limit $4800 for a family of four). Up to 60 days of hospital care; all doctor bills; ancillary services; unlimited nursing home care; prenatal and care up to age 18*; mental health*; family plan.*	All hospital and doctor bills; ancillary services; up to 100 days of post-hospital extended care; 30 days in hospitals for mental health; ambulances; outpatient drugs after $50; 100 days of home health services*; well-child care to age 6 (after $150 deduction); dentistry, vision, hearing services, including hearing aids and glasses, to age 13*; maternity and family planning.*
POSITIVE HEALTH CONCEPT	Under Title I there is no positive health concept. Under Title II those services listed under Comprehensive Services with an (*) are considered preventive.	Basically insurance for illness concept. All services except those above with an (*) in the Comprehensive Coverage Section relate to treatment rather than prevention. There is option of HMO where available.
FINANCING: **Trust Fund;** **Progressive Tax Based on Ability to Pay;** **No Deductibles**	Medical assistance trust fund for Title II established from federal revenues and state contributions equal to current medicaid costs. No deductibles except $3 per visit for first 10 doctors visits. Persons in nursing homes more than 60 days, with no dependents, must contribute all income over $50. An increase of .3¢ in social security taxes finance Title I. Deductibles Titles I & II: After catastrophic coverage, patient pays $17.50 a day and 20¢ of all bills up to $1,000.	No trust fund. Employers pay at least 75¢ of insurance premium, employees the remainder. Federal costs come out of general revenues (persons earning less than $7,500 per year). Deductibles: the first $150 a year in medical bills for each family member up to family limit $450. Patient pays 25¢ of all bills exceeding decutible until out-of-pocket expenses exceed $1500. Adjustments for low income persons.
ACCESS TO HEALTH CARE AS EVERY PERSON'S RIGHT	The Social Security Administration would run the program, using private insurance companies as carriers or intermediates for catastrophic and low-income coverage. HEW sets up *voluntary* guidelines for private health insurance plans, which most persons would purchase as they do now.	Health card ineffective when unpaid bills 90 days in arrears. All employers would have to offer insurance through private companies meeting minimum benefit standards. A federal-state subsidized program would offer the same benefits to the unemployed, the poor, high health risks. Medicare continues expanded. Individuals could choose not to purchase insurance. States would administer program and regulate companies selling insurance.
PROVISION FOR QUALITY CARE	No provisions for quality.	No provision for quality.
PERSONNEL DEVELOPMENT/ DEPLOYMENT: **Manpower** **Research** **Facilities**	No funds for development.	No funds included for development.

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G-33 15 April

FRIENDS COMMITTEE ON NATIONAL LEGISLATION
245 Second Street, N.E., Washington, D.C. 20002

Supreme Court, U. S.
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APR 25 1975

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,

Petitioners,

—v.—

WILLIAM E. SIMON,
Secretary of the Treasury, *et al.*,

Respondents.

IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

BRIEF *AMICUS CURIAE* OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

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Supreme Court of the United States

OCTOBER TERM, 1974

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WILLIAM E. SIMON,
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Respondents.

IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

BRIEF *AMICUS CURIAE* OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Interest of the American Public Health Association

This Brief is presented in support of the Petition for Writ of Certiorari filed on behalf of Eastern Kentucky Welfare Rights Organization, *et al.* Counsel for both the petitioners and respondents have consented to the filing of the instant Brief *amicus curiae*.

The American Public Health Association is a national non-governmental organization established in 1872. Its object is to protect and promote personal and environmental health. With a membership of over 50,000, it is the largest public health organization in the world. Within

this membership, both professional health workers and consumers act in a leadership role to develop a national health policy to provide equitable, low-cost, quality health care for all citizens. At its annual convention in 1970, the APHA took note of the fact that many non-profit hospitals in the United States had failed to live up to their legal obligations to make free and below cost care available to persons unable to pay.

The APHA believes that through Revenue Ruling 69-545 the Internal Revenue Service destroyed rights of vital importance to the health of millions of Americans. We are deeply disturbed that the IRS effectuated this major change in federal policy apparently on the basis of erroneous assumptions of fact and without affording health professionals or the public an opportunity to provide information and comment.

Summary of Argument

For over thirty years the non-profit hospitals of America have received massive government subsidy, both direct and indirect, on the basis of representations and legal requirements that they provide charitable services to people unable to pay. The Internal Revenue Service, in Revenue Ruling 69-545, abolishes the requirement that hospitals enjoying tax exempt status must provide free care to those unable to pay. This change in the tax treatment of non-profit hospitals was specifically rejected by the Congress.

Over one-fifth of the American population has no hospital insurance. In recent years the net income of non-profit hospitals has increased at a rapid pace while the

public hospital sector has found it increasingly difficult to provide necessary services to the growing numbers of people who are unable to pay for hospital services.

The IRS decision to abolish the requirement that tax exempt hospitals must provide free care to those unable to pay is based on factual assumptions about the delivery of health care in America. Even though the IRS has no particular expertise in this area, they proceeded without providing the public or the health professions any opportunity to provide information or comment.

ARGUMENTS

I. Revenue Ruling 69-545 impermissibly effects a major change in established federal policy in relation to both the provision of hospital services and charitable tax exemption.

One of the most important devices which Congress uses to encourage activities which it believes will be useful to the Nation is to grant exemption from the taxes which would otherwise be collected, and to allow deductions for private contributions to designated activities. In Section 501(c)(3) of the Internal Revenue Code, Congress provided in broad terms that non-profit organizations which provide charity are tax exempt.[1] The courts below found that the intended beneficiaries of the charitable services upon which this exemption is based have sufficient interest in the receipt of those services to allow them standing to challenge the action of the Internal Revenue

[1] Int. Rev. Code of 1954, 26 U.S.C. §501(c)(3). The statute is set forth in the Petition for Writ of Certiorari, p. 64a.

Service in abolishing rights which would otherwise be theirs. The APHA supports this decision.

Section 501(c)(3) also grants tax exemption to certain classes of activities which Congress has deemed inherently useful, whether or not they are provided on a charitable basis. (For example, education, scientific study for public safety, prevention of cruelty to children or animals.) The Petitioner's Application for a Writ of Certiorari raises two questions of fundamental importance. First, whether the Internal Revenue Service has the power to eliminate the requirement that tax exempt hospitals provide "charity" and thereby expand the class of non-profit activities which shall be considered *per se* worthy of tax exempt status under 501(c)(3), or whether that power rests with the Congress. And second, whether the Administrative Procedure Act requires that in eliminating the right to expect charitable services from non-profit tax-exempt hospitals, the Internal Revenue Service should obtain information and comment from the public and professionals who have some particular knowledge and interest in health care delivery.

Revenue Ruling 69-545 effects a major change in long standing federal tax exemption policy, which is not authorized by the statute and which, indeed, was explicitly rejected by the Congress.[2] To qualify for exemption under the plain language of the Code, a hospital must be both non-profit *and* charitable. The class of people dependent upon non-profit tax exempt hospitals to provide them with needed hospital care was large when the action was filed. Unfortunately it is now growing astronomically. Despite

[2] See opinion of the district court below, Petition for Writ of Certiorari, pp. 552a-56a.

the growth of private insurance and the enactment of Medicaid and Medicare, the Social Security Administration estimates that in 1972, one-fifth of the population under the age of 65 had no financial shield against the hazards of illness. Still larger numbers had only minimal insurance protection.[3] 38 million Americans under age 65 had no hospital insurance and 43 million had no insurance for medical care costs.[4]

Since February 1972 the official unemployment rate has risen from 5.8% to 8.2%.[5] The 8.2% rate of unemployment represents more than 7.5 million workers.[6] High unemployment has a direct and drastic impact on the number of persons who have no insurance or other third party coverage for hospital costs. The recent Staff Report of the House Committee on Interstate and Foreign Commerce notes that although a variety of bills have been introduced in Congress to provide federal funds to pay health insurance premiums for unemployment compensation recipients who had health insurance at their previous place of employment, even if these bills are enacted, large numbers of unemployed persons would still be without hospital coverage. Under the bills, two large classes are excluded. First, many of the unemployed are not eligible for unemployment compensation for a variety of reasons; this group is estimated to number at least 1.5 million out of the 7.5

[3] M. S. Mueller, "Private Health Insurance in 1972: Health Care Services, Enrollment, and Finances," Social Security Bulletin, March 1974 at 21.

[4] *Id.* at 20.

[5] Bureau of Labor Statistics, as cited in Staff of House Comm. on Interstate and Foreign Commerce, 94 Cong. 1st Sess., "Health Insurance and the Unemployed," March 10, 1975, at 11. Also Bulletin Almanac, 1974, at 194.

[6] *Id.* at 12-20.

million unemployed.[7] The second group of ineligibles are those unemployed persons who are drawing unemployment benefits, but did not have health insurance coverage at their previous place of employment. Most employers have a waiting period before workers are eligible to participate in group health programs. Since the last hired are often the first fired, "it is easy to see that the probability exists for many to be laid off before gaining eligibility to the health plan."[8]

The previously well established rights of this growing class of people are at stake in this case. For almost three decades it has been the firm federal policy of this country to encourage and assist the development of the non-profit voluntary hospital, which would be available to serve all members of the community. In 1946 Congress enacted the Hospital Survey and Construction Act, to create, through the voluntary sector, "a state-wide system of hospitals for the provision of hospital services to all the people of the state."[9] Over 470,000 hospital beds were constructed with these federal funds between 1947 and 1971. Over 280,611, or 59.7% of these federally financed beds are located in private, non-profit community hospitals.[10] Over the years the American Hospital Association has solicited funds from both the government and the American people on the premise that hospital services would be available to people who need them, without regard to ability to pay. For example, in 1969, Mark Burke, then President Elect of

[7] *Id.* at 3 and 20.

[8] *Id.* at 33.

[9] *Simkins* v. *Moses H. Cone Mem. Hosp.*, 323 F.2d 959, 968 (4th Cir. 1963) (*en banc*), *cert. denied*, 376 U.S. 938 (1964).

[10] DHEW, Public Health Services, "Hill-Burton Project Register, July 1, 1947-June 30, 1971," Doc. No. 72-4011, p. 21.

the American Hospital Association, told the House Committee on Ways and Means:

> "The institutional health care system differs from the rest of the private sector in its philosophy toward and treatment of patients who are unable or unwilling to pay. Other members of the private sector maintain their right not to sell their product to someone who cannot afford it . . . Community hospitals, because of their public responsibility do not take such action. The right to receive such service regardless of the ability to pay is extended to the entire community."[11]

Revenue Ruling 69-545 flies in the face of the clear federal policy encouraging the development of non-profit charitable hospitals to serve the community, particularly that portion of the community which is unable to pay for hospital services either directly or through insurance.

Revenue Ruling 69-545 does not require non-profit hospitals to provide charity in any accepted sense of the word. It requires hospitals to accept patients whose health insurance is financed through the Medicaid and Medicare programs. Despite the statement of the American Hospital Association to the contrary,[12] Medicaid and Medicare pay hospitals the full reasonable costs of the services provided to individuals who are insured under these programs.[13]

[11] Hearings on Social Security and Welfare Proposals before the House Comm. on Ways and Means, 91st Cong. 1st Sess., Pt. 4, at 1069 (1969).

[12] Brief *Amicus Curiae* of the American Hospital Association, at n. 3.

[13] See *Catholic Medical Center* v. *Rockefeller*, 305 F. Supp. 1256 (E.D.N.Y. 1969), vacated and remanded, 397 U.S. 820 (1970), order reentered, 305 F. Supp. 1268 (E.D.N.Y. 1970), aff'd *per*

Hence this requirement is nothing more than a statement that exempt hospitals may not arbitrarily discriminate against certain classes of people who are able to pay the full cost of the service. Sound policy reasons support a rule that tax exempt hospitals should not arbitrarily discriminate against particular groups of people who are fully able to pay, whether that discrimination is based on race, age or economic class. However, prohibiting arbitrary discrimination against particular classes of paying patients, does not meet the statutory requirement that a non-profit hospital must provide charity in order to be tax exempt.

Similarly, the requirement that a non-profit hospital have an emergency room does not require that the hospital provide charity. Certainly emergency room service is an important component of any general hospital. Over 37% of the non-profit hospitals in this country do not have "basic emergency services."[14] But the mere existence of an emergency room does not assure that charitable services will be provided. The widespread policy of many non-

curiam, 430 F.2d 1297 (2d Cir. 1970), appeal dismissed, 400 U.S. 931 (1970).

See also 39 Fed. Reg. 31766 (1974), in which the Secretary of HEW notes that the federal Medicaid law requires full payment of all reasonable costs and states: "Concern has been expressed by representatives of the American Hospital Association that some States have in the past, in violation of their Title XIX State plans, failed to reimburse hospitals at the required reasonable cost level . . . The Secretary knows of no instance, however, in which such a violation has occurred without being promptly rectified with full reasonable cost reimbursement of all services provided by hospitals. If there should in the future be any instance in which States fail to adhere to State plan requirements, affected hospitals are urged to so inform the appropriate Regional Commissioner of the Social and Rehabilitation Service."

[14] Journal of the American Hospital Association, Guide Issue, 484 (Aug. 1971).

profit hospitals is to "dump" on to the public hospitals any patients who lack money or insurance and who require hospitalization and other services.[15] Revenue Ruling 69-545 requires only that a tax exempt hospital have an emergency room. The hospitals are entirely free to transfer all uninsured patients to the public hospital, if that is the hospital's choice. Revenue Ruling 69-545 does not assure that any charitable care will be provided by the non-profit organization enjoying the benefit of tax exemption.

In 1969 the Internal Revenue Service sought Congressional authorization for the specific policy embodied in Revenue Ruling 69-545. Congress refused to provide that authorization. To free the non-profit tax exempt hospitals from the long standing obligation to provide charitable care to those unable to pay obviously represents a fundamental change in federal policy with respect to both hospital services and tax exemption. Congress was not willing to make that change.[16] Respondents have exceeded their legal authority in thus amending the tax law. The fundamental importance of the rights at stake warrant the review of this Honorable Court.

[15] See Roemer & Mera, "Patient Dumping and Other Voluntary Agency Contributions to Public Agency Problems," 11 Med. Care 30 (Jan.-Feb. 1973). Woodward, "Poor Hurt by Transfers, Doctor Says," Washington Post, Sept. 30, 1971, at 17, col. 1.

[16] See discussion in the Opinion of the District Court below, Petition for Writ of Certiorari, pp. 55a-56a.

II. Revenue Ruling 69-545, and the decision of the court below are based on erroneous assumptions about health care delivery.

This Court should grant certiorari to assure that fundamental changes in federal policy are adopted in accordance with the requirements of the Administrative Procedure Act providing interested parties an opportunity to place the essential information before the governing agency.

The opinion of the Circuit Court upholding Revenue Ruling 69-545 as a permissible exercise of IRS discretion is based on "factual assumptions which are not supported by a record and which plaintiffs have not had an opportunity to rebut." [17] We respectfully submit that the factual assumptions of the Circuit Court are, quite simply, wrong. The Circuit Court assumed that, "the institution of Medicare and Medicaid in the last decade combined with the rapid growth of medical and hospital insurance has greatly reduced the number of poor people requiring free or below cost hospital services." [18] We have already shown that this assumption is tragically inaccurate. The Circuit Court also seems to assume that because of rising hospital costs and reduced philanthropic contributions the private non-profit hospitals are not able to provide a significant amount of free and below cost care. The third assumption is that local government is increasingly able to provide non-emergency hospital care for those unable to pay.

[17] Opinion of Bazelon, C.J. dissenting from denial of Motion for rehearing *en banc*, set forth in Petition for Writ of Certiorari, at p. 3a.

[18] The opinion is set forth in the Petition for Writ of Certiorari. See pp. 24a-25a.

Despite a decrease in the amount of philanthropic contributions, non-profit hospitals in America have never been in better financial shape. The most recent Social Security Administration study of the subject shows that during the period 1961-71, the net income as a rate of return on plant assets in non-profit hospitals rose from 1.4% to 3.0%.[19] Stated another way, in non-governmental community hospitals total revenue rose from $5.0 billion in 1961 to $18 billion in 1971, while expenses increased at a lesser rate, from $4.9 billion to $17.6. This HEW study summarizes, "overall *net* income grew tremendously, from $110 million in 1961 to $547 million in 1971." [20]

What does a non-profit hospital do when it has a substantial excess of income over expenses, as has been the case in recent years? It could increase the amount of free and below cost care which it provides to people unable to pay. Or, as has more often been the case in American hospitals, it could build a new wing. In 1974, conservative estimates, both governmental and private, placed the number of excess, unnecessary acute care hospital beds in America at between 67,000 and 110,000.[21] In 1974, 4.5

[19] J. Pettengill, "The Financial Position of Private Community Hospitals, 1961-71," Social Security Bulletin, Nov. 1973, at 10.

[20] *Id.* at p. 3.

[21] In 1972 the federal Hill-Burton agency estimated that there were 110,000 excess acute care hospital beds in the United States. DHEW Health Resources Administration, Health Care Facilities Services, "General Hospitals and Outpatient Facilities, Existing and Needed as of Jan. 1, 1971" (1972). The 67,000 estimate of excess beds is based on a private study assuming that an optimal nation-wide occupancy rate is 81%. Sattler & Bennett, "A Statistical Profile of Short Term Hospitals in the U.S. as of 1972," Interstudy, Minneapolis, Minn. (1974). These reports are summarized at 120 Cong. Rec. 22259 (Daily Ed. Dec. 19, 1974).

billion dollars was spent for the construction of yet more new hospital beds.[22] Since it costs an average of $20,000 a year to maintain the standby, operational costs of each empty hospital bed, we paid about $2 billion in 1974, through public and private insurance programs, to maintain unneeded, unused hospital beds.[23] Stated another way, in 1974, $60 was added to the cost of each hospital stay in the United States simply to finance the maintenance of empty, unnecessary hospital beds.[24]

As serious as this waste of money is, even more tragic is the resulting loss of human life. It has long been recognized that where a substantial proportion of the population have pre-paid hospital insurance, there is a definite tendency to fill the hospital beds. This tendency, known in the health delivery field, as Roemer's Law, was first formally observed by Milton I. Roemer, a long standing active member of the American Public Health Association.[25] Other more recent studies have shown a close correlation between the number of hospital beds and the amount of

[22] Remarks of Eugene Rubell, Director Bureau of Health Planning Service and Resources Development, HEW, "Excess Hospital Construction Blocked," N.Y. Times, Dec. 16, 1974, at 14, col. 4.

[23] Regional Health Planning Council, North Central Texas Council of Governments, "The Financial Impact of Hospital Overbedding," June 1974. See also Lave and Lave, "Hospital Cost Functions," LX Am. Econ. Rev. 3 (1970).

[24] C. B. Ensminger, "The Eight Billion Dollar Hospital Bed Overrun," Health Research Group, Wash., D.C., 1975, at 1.

[25] M. Shaine and M. I. Roemer, "Hospital Costs Relate to the Supply of Beds," 92 Mod. Hosp. 71 (April 1959); M. I. Roemer, "Bed Supply and Hospital Utilization: A Natural Experiment," 35 Hospitals 36 (Nov. 1, 1961).

elective surgery.[26] A recent study by the General Accounting Office estimated that 25% of the hospital beds in America are filled with people who do not need to be there.[27] Approximately three million unnecessary elective surgical procedures were performed in the United States in 1973.[28] Given the risks inherent whenever an individual undergoes general anesthesia for surgery, it is apparent that a large number of lives are unnecessarily lost each year as a result of unnecessary elective surgery. We might all be better off, both financially and physically, if non-profit hospitals devoted a greater proportion of their excess resources to providing necessary services to people who are unable to pay, and less to the construction of further unnecessary inpatient facilities.

The third operative assumption of the court below is that "increasingly counties and other political subdivisions are providing non-emergency hospitalization and medical care for those unable to pay."[29] The contribution of local government to the cost of health care has increased dramatically in recent years, both through the pro-

[26] See Dr. C. Lewis, "Variations in the Incidence of Surgery," 281 N. Eng. J. of Med. 889 (1969).

[27] General Accounting Office, "Study of Health Facility Construction Cost," Report to the Congress by the Comptroller General, 1972, at 759.

[28] Various studies estimate that 20% of elective surgery performed in this country is unnecessary. McCarthy, "Effects of Screening by Consultants on Recommended Surgical Procedures," 291 N. Eng. J. of Med. 1331 (1974). Dr. L. Williams, ***How to Avoid Unnecessary Surgery***, Nash Pub. 1971. See also, MacLeod & Prussin, "The Continuing Evolution of Health Maintenance Organizations," 288 N. Eng. J. of Med. 439 (1973). In 1973 there were 15.4 million elective surgical procedures performed under general anesthesia. American Hospital Association, ***Hospital Statistics, 1974***, at 34.

[29] Petition for Writ of Certiorari, p. 24a.

vision of service in public hospitals and through local financial contribution to the cost of care provided in private hospitals.[30] However, it is also well known that local governments in many areas face serious financial problems which make it difficult to expect them to take up the provision of charity hospital care which has historically been the responsibility of the non-profit, tax exempt hospitals.

The American Public Health Association believes that Revenue Ruling 69-545 represents a drastic change in the previous law, eliminates important rights of the citizens whom Petitioners represent, has a substantial impact upon both the public and private sectors of the hospital industry, and is necessarily predicated upon assumptions of fact which are not within the particular expertise of the Respondent. Under settled principles, all of these reasons require that the Respondent comply with the rule making procedures of the Administrative Procedure Act.[31] If the Respondent had complied with the procedures mandated by the Administrative Procedure Act, and had received a full range of relevant information, we believe that the policy change effectuated by Ruling 69-545 might never have been made.

---

[30] Between 1966 and 1973 the percentage of national health care expenditures financed through public funds increased from 25.7% to 39.9%. B. Cooper, *et al.*, "National Health Expenditures, 1929-73," Social Security Bulletin, March 1974, p. 4. During the same period the aggregate contribution to health care services from state and local sources increased from $4,542 million in 1966 to $10,230 million in 1973. *Id.* at p. 15. *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250 (1974) may cause further increases in state and local contribution to health care services for short term residents.

[31] See *Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402 (1971). See also *Lewis-Mota* v. *Secretary of Labor*, 469 F.2d 478 (2d Cir. 1972); *Texaco* v. *Federal Power Comm'n*, 412 F.2d 740 (3d Cir. 1969).

CONCLUSION

For the foregoing reasons, it is respectfully submitted that the Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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APPENDIX

IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,

Petitioners

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,

Respondents

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Petitioners

v.

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR CERTIORARI IN 74-1110 FILED MARCH 6, 1975
PETITION FOR CERTIORARI IN 74-1124 FILED MARCH 8, 1975
CERTIORARI GRANTED AND CASES CONSOLIDATED MAY 19, 1975

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CIVIL DOCKET

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

C.A. No. 1378-71

EASTERN KENTUCKY WELFARE, ET AL

vs.

JOHN CONNALLY, ET AL

Attorneys:
Anthony Z. Roisman
1712 N Street, N.W.
Washington, D.C. 20036
Marilyn G. Rose
1751 N St., N.W. 20009

PARTIES

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION

CALIFORNIA WELFARE RIGHTS

NATIONAL TENANTS ORGANIZATION

ASSOCIATION OF DISABLED MINERS AND WIDOWS

HEALTH, EDUCATION, ADVISORY TEAM, INC.

HENRY AND CAROLYN BLOCK

VIRGINIA STEPHENS

TORA MAE COLLINS

ARTIE TACKETT

BALLARD CABLE

JOEY JAY BLEVINS

MARY AND JAY BLEVINS

ROSEZELLA COOK

SHIRLEY LAMPTON

MONICA HUNTER

vs

1. JOHN CONNALLY

2. HAROLD T. SWARTZ

Jack B. Teplitz
Dept. of Justice

CIVIL DOCKET

DATE	PROCEEDINGS
1971	
	Deposit for cost by
July 12	Complaint, appearance. filed
July 12	Summons, copies (4) and copies (4) of Complaint issued; all served on 7-13.
July 12	Certificate of service. filed
Sept. 13	Stipulation extending time for defts. to respond to 11-8-71. (Fiat) Jones, J.
Nov. 5	Motion of defts. for extension of time to answer or otherwise plead; c/m 11-5-71; Appearance of Jack B. Teplitz. filed
Nov. 12	Order extending time to 11-18-71 within which defts. may answer or otherwise respond to the complaint. (N) Parker, J.
Nov. 18	Motion of defts. to dismiss; P&A's; attachment A; c/m 11-18-71; M.C. filed

DATE	PROCEEDINGS
1971	
Dec. 2	Motion of pltfs. for extension of time; P&A; c/m 11-29-71; M.C. filed
Dec. 13	Order extending time for pltfs. to respond to defts. motion to dismiss to 12-17-71. (N) Parker, J.
Dec. 16	Response of pltfs. in opposition to defts. motion to dismiss; c/m 12-10-71. filed
Dec. 22	Correction sheet (erratum) by pltfs; c/m 12-20-71. filed
1972	
Jan. 10	Change of address of Marilyn G. Rose, co-counsel for pltfs; c/m 1-5-72. filed
Jan. 27	Supplemental memorandum of pltfs. in response to defts. motion to dismiss; c/m 1-25. filed
Apr. 28	Motion of deft. to dismiss, denied. Order to be presented. Parker J.
May 10	Order denying motion of defts. to dismiss complaint. (N) Parker J.
May 26	Answer of defendants to complaint; c/m 5-25.
July 24	Status report. Case will be certified to pretrial on 12-1-72. Parker J.
1973	
Apr. 10	Motion of pltfs for summary judgment against defts; P & A index; statement; index of exhibits; exhibits 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14-A, B, c, d, e, f, g, h, i, j, k, k-7, 15; c/m 4/10/73 M.C.
Apr. 12	Motion of defts for additional time to respond to motion for summary judgment; P & A; c/m 4/12/73. M.C.
Apr. 17	Motion of pltf's for leave to file supplemental affidavit P & A. Exhibit. c/m 4/16. M.C.

DATE	PROCEEDINGS
1973	
Apr. 17	Order allowing defts. until 5-25-73, to respond to pltfs. motion for summary judgment. (N) Parker, J.
Apr. 23	Motion of pltf for leave to file supplemental affidavit, granted. (fiat) (N) Parker, J.
May 29	Stipulation extending time within which defts may file response to pltfs motion for summary judgment to 6-8-73 (N) Parker, J.
June 7	Change of address of Anthony Z. Roisman to 1712 N Street, N:W.
June 27	CROSS-MOTION of defts for summary judgment; P & A; statement; c/m 6/27/73. M.C.
July 12	OPPOSITION by pltffs. to defts' cross-motion for summary judgment; appendix A, B, and C; c/s 7/12/73.
July 20	OBJECTIONS by defts. to pltffs. statement of material facts; c/m 7/20/73.
Aug. 6	MOTION of pltffs. for sanctions; exhibit 1—appendix A and B; P & A's; c/m 8-2-73.
Aug. 8	MOTION of defts. for leave of Court to file affidavits and letter; P & A; exhibits (10) c/s 8-7
Aug. 8	MOTION of defts. for leave of Court to file statement of genuine issues; P & A; exhibit. c/m 8-7
Aug. 8	MEMORANDUM of defts. in opposition to pltfs' motion for sanctions against defts, award of attorneys' fees, striking of defts' objections to pltfs' statement of material facts, and finding that there is no dispute of material facts. c/s 8-8

DATE	PROCEEDINGS
1973	
Aug. 10	SECOND motion of pltfs. for sanctions against defts, and their attorneys, award of attorneys' fees, opposition to motions for leave to file statement of genuine issues and affidavits and letter, and alternative finding that whether or not such affidavits and letter are considered, there is no dispute of material facts; P&A. c/s 8-10
Aug. 15	MOTION of pltffs. for summary judgment taken under advisement. Motion of defts. for summary judgment taken under advisement. Each to submit proposed findings of fact, conclusions of law and proposed order by 9-17-73. (Rep: G. Nevitt) Parker, J.
Aug. 22	CITATIONS by defts. of cases and other authorities; attachment (1); c/m 8/22/73.
Sept. 17	PROPOSED Findings of Fact & Conclusions of Law by defts. c/m 9-17.
Sept. 18	PROPOSED Findings of Fact & Conclusions of Law by pltfs. c/m 9-13
Dec. 20	MEMORANDUM OPINION denying cross-motion of deft. for summary judgment and granting motion of pltfs. for summary judgment. (N) Parker, J.
1974	
Jan. 9	OBJECTIONS of defts. to proposed order of pltfs.; attachment; c/m 1-9-74.
Jan. 14	APPLICATION of American Hospital Association to intervene as amicus curiae and for reconsideration of the Court's memorandum opinion of 12-20-73; P&A's; affidavit of John E. Sullivan; c/m 1-11-74.

DATE	PROCEEDINGS
1974	
Jan. 21	OPPOSITION of pltfs. to the application by the American Hospital Association to intervene as amicus curiae and for reconsideration of the Court's memorandum opinion of 12-20-73; c/m 1-21-74.
Jan. 22	RESPONSE by pltfs. to objections of defts. to proposed order of pltfs.; appendix A; appendix B; c/s 1-14-74.
Jan. 25	RESPONSE of the American Hospital Association to opposition by pltfs. to the application of The American Hospital Association to intervene as amicus curiae and for reconsideration of the Court's memorandum opinion of 12-20-73; c/m 1-24-74.
Jan. 28	MEMORANDUM ORDER denying leave to intervene by American Hospital Association as amicus curiae. (N) Parker, J.
Jan. 29	ORDER directing entry of a judgment in favor of pltfs. (N) Parker, J.
Feb. 6	MOTION by deft for stay of enforcement of the injunctive relief provisions of the Court's order entered on January 29, 1974; P & A's; c/m 2-6-74.
Feb. 15	OPPOSITION by pltfs. to defts. motion for stay of enforcement of the injunctive relief provisions of the Court's Order; c/m 2-15-74.
Feb. 21	NOTICE of change of address of counsel for pltfs.; c/m 2-8-74; CD/N
Feb. 21	ORDER denying motion of defts. to stay enforcement of the Order entered on 1-29-74. (N) Parker, J.

DATE	PROCEEDINGS
1974	
Feb. 22	NOTICE of appeal by defts. from ORDER of 1-29-74. Copies mailed to Anthony Roisman and Marilyn G. Rose; c/m 2-22-74.
Feb. 26	PRELIMINARY record delivered to USCA; receipt acknowledged.
Mar. 6	NOTICE by counsel Laurens H. Silver of change of address to 311 California St., Suite 301, San Francisco, California 94104
Mar. 14	COPY of SUPPLEMENTAL memorandum by defts. in support of motion for stay; c/s 3-14-74.
Mar. 26	LETTER from defts. attorney re: copy of second supplementary memorandum in support of motion to stay filed in U.S. Court of Appeals; exhibit.
Apr. 1	PROGRESS REPORT by defts. taken to implement this Court's Order of 1-29-74; attachments (2); c/m 4-1-74.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

PARKER, J.

[Filed Jul. 21, 1971, James F. Davey, Clerk]
Civil Action No. 1378-71

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION
c/o Mrs. Eula Hall
Craylor, Kentucky

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1442 E. Florence Avenue
Los Angeles, California

NATIONAL TENANTS ORGANIZATION
425 - 13th Street, N.W.
Washington, D.C.

ASSOCIATION OF DISABLED MINERS AND WIDOWS
Madison, West Virginia

HEALTH, EDUCATION, ADVISORY TEAM, INC.
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Fairmont, West Virginia

HENRY AND CAROLYN BLOCK
729 E. Mabel Street
Tucson, Arizona

VIRGINIA STEPHENS
Harold, Kentucky

TORA MAE COLLINS
Tram, Kentucky

ARTIE TACKETT
Harold, Kentucky

BALLARD CABLE
Harold, Kentucky

JOEY JAY BLEVINS, a minor,
by his parents and guardians
MARY AND JAY BLEVINS
Honaker, Kentucky

ROSEZELLA COOK
2652 Alvar Street
New Orleans, Louisiana

SHIRLEY LAMPTON
2636 Mazant Street, Apt. E
New Orleans, Louisiana, and

MONICA HUNTER
416 N. Viller Street
New Orleans, Louisiana

On their own behalf and on behalf of
all other persons similarly situated,
Plaintiffs,

vs.

JOHN CONNALLY, as Secretary of the Treasury of the United States, Department of the Treasury, Washington, D.C., and

HAROLD T. SWARTZ, as Acting Commissioner of Internal Revenue, Internal Revenue Service, Washington, D.C.
Defendants.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

1. PLAINTIFFS invoke the jurisdiction of this Court under 28 U.S.C. 1331, 1340, and 1361, 28 U.S.C. 2201 and 2202 and 5 U.S.C. 702 and 703. The value of the rights asserted exceeds $10,000 for each individual PLAINTIFF.

2. This is an action for declaratory and injunctive relief, declaring the rights of poor people to receive services without charge from private hospitals which receive federal tax exemptions as "charitable" institutions under 28 U.S.C. 501(c)(3), and restraining and enjoining DEFENDANTS from granting or continuing to grant tax exemptions to private hospitals which refuse admission and free services to persons unable to pay, in contravention of the Internal Revenue Code of 1954. PLAINTIFFS also seek to compel DEFENDANTS to institute proceedings leading to the revocation of the tax exempt status of private hospitals which deny admission and service to persons unable to pay, to revoke a general ruling entitling said hospitals to tax exempt status as "charitable", and to collect all taxes due and owing because of said illegal designation.

3. Monetary damages are inadequate and no adequate remedy at law is available to individual PLAINTIFFS and others similarly situated who have suffered and will continue to suffer irreparable harm and the threat of irreparable harm from the action of DEFENDANTS complained of herein.

PARTIES

4. PLAINTIFF, EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, is a nonprofit corporation organized under the laws of Kentucky whose members include low income persons primarily residents of Floyd County, Kentucky with a chapter in Pike County, Kentucky. EKWRO was organized to represent and promote the social welfare of recipients of public assistance programs, Social Security and Medicaid and of other low income persons in the eastern section of Kentucky, including Floyd and Pike Counties, in a broad range of activities, including, *inter alia*, the needs and

interests of such persons in obtaining health and hospital care and services. Its members and the persons it represents are intended to be protected by, and are the beneficiaries of, the "charitable" tax provisions of the Internal Revenue Code of 1954.

5. PLAINTIFF, CALIFORNIA WELFARE RIGHTS ORGANIZATION, is an unincorporated association organized to represent and promote the social welfare of recipients of public assistance programs and Medi-Cal and of other low income persons in the State of California in a broad range of activities, including, *inter alia*, the needs and interests of such persons in obtaining health and hospital care and services. Its members and the persons it represents are intended to be protected by, and are beneficiaries of, the "charitable" tax provisions of the Internal Revenue Code of 1954.

6. PLAINTIFF, NATIONAL TENANTS ORGANIZATION, is a nation-wide nonprofit corporation organized to represent and promote the social welfare of its memberships, which is almost entirely low income tenants, in a broad range of activities including *inter alia*, the needs and interests of such persons in obtaining health and hospital care and services. Its members and the persons it represents are intended to be protected by, and are beneficiaries of, the "charitable" tax provisions of the Internal Revenue Code of 1954.

7. PLAINTIFF, ASSOCIATION OF DISABLED MINERS AND WIDOWS, INC., is a nonprofit corporation representing approximately 4,000 disabled miners and widows of miners who reside primarily in the Appalachian coal field states of West Virginia, Kentucky, Tennessee, Virginia, Ohio, Pennsylvania, and Maryland with scattered memberships in other states. It represents its members in a range of social health and welfare purposes including their special health and hospital needs.

The disabled miners in its memberships all have serious health problems which range from pneumoconiosis (black lung) to traumatic work connected injuries, to heart and other problems which require frequent health services. The income of each member is derived principally from social security disability benefits and/or workmen's compensation which places them below the OEO poverty guidelines. The members lack private health insurance, health benefits under employment and union contracts, Medicaid, and the means to pay for hospital services, and are persons intended to be protected by, and are beneficiaries of the "charitable" tax provisions of the Internal Revenue Code of 1954.

8. PLAINTIFF, HEALTH, EDUCATION, ADVISORY TEAM, INC., is a nonprofit corporation in Marion County, West Virginia, with 2,000 members, organized and funded under a Department of Public Health grant to promote the access of poor people to health care services. Its members and the persons it represents are intended to be protected by, and are the beneficiaries of, the "charitable" tax provisions of the Internal Revenue Code of 1954.

9. Individual PLAINTIFFS HENRY AND CAROLYN BLOCK, VIRGINIA STEPHENS, TORA MAE COLLINS, ARTIE TACKETT, BALLARD CABLE, JOEY JAY BLEVINS, a minor, by his parents and guardians, MARY AND JAY BLEVINS, ROSEZELLA COOK, MONICA HUNTER and SHIRLEY LAMPTON, are citizens of the United States and of the States in which they reside. They are poor people, the sole income for them and their families being principally derived from public assistance, and/or Social Security Survivor Benefits, and/or minimal employment. All individual PLAINTIFFS and their families subsist below the poverty income levels set by the U.S. Department of Labor and the poverty guidelines of the Office of Economic Opportunity. They all suffer from, or have suffered from, various medical conditions requiring health and hospital services and are persons intended to be protected by, and are beneficiaries of, the "charitable" tax provisions of the Internal Revenue Code of 1954.

10. The organization PLAINTIFFS sue on behalf of their members. Each individual PLAINTIFF sues on her or his own behalf and on behalf of all other persons similarly situated as alleged hereinafter. This is a proper class action under Rule 23, Federal Rules of Civil Procedure. The class is so numerous that joinder of all members of the class is impracticable; the claims of the individual PLAINTIFFS are typical of the claims of the class; and the named PLAINTIFFS will fairly and adequately protect the interests of the class. The DEFENDANTS have acted and have refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief with respect to the class as a whole.

11. DEFENDANT JOHN CONNALLY is Secretary of the Treasury of the United States and has his principal place of business in Washington, D.C. DEFENDANT HAROLD T. SWARTZ is Acting Commissioner of Internal Revenue and has his principal place of business in Washington, D.C. Both DEFENDANTS have the responsibility and authority to administer and enforce the Internal Revenue Code of 1954.

STATEMENT OF FACTS

12. The Internal Revenue Code of 1954 provides certain tax exemptions and benefits for institutions classified under its provisions as "charitable", to wit: institutions which qualify as charitable are exempted from payment of federal income taxes by virtue of 26 U.S.C. 501(c)(3); contributions to such institutions are deduc-

tible from gross income on individual and corporate income tax returns by virtue of 26 U.S.C. 170(a) through (c); such institutions and donors to such institutions are also eligible for other federal tax benefits and advantages under Sections 642(c), 2055, 2106(a)(2) and 2522 of 26 U.S.C.

13. Upon information and belief, throughout the United States there are approximately 3500 private hospitals which claim eligibility as "charitable" under these provisions, file the pertinent forms claiming such eligible status, and have been determined as such by DEFENDANTS or their agents. The amount of monies which otherwise would be taxable as income of such hospitals or which otherwise could not be deducted from taxable income by donors to such hospitals is substantial. In fiscal 1969 alone these hospitals have received $2.3 billion from charitable contributions.

14. The consistent legislative history relevant to Section 501(c)(3) and its predecessors as well as the commonly accepted definition establishes that "charitable" means "relief of the poor." The Internal Revenue Service has consistently included in its regulations a definition of the term "charitable" to mean "relief of the poor." Since 1940 the Internal Revenue Service has litigated before Federal and Tax Courts the issue of the tax exempt status of private hospitals and claimed that private hospitals are not eligible for such status if they refused services to persons in need of hospital care but unable to pay. In 1956 the Internal Revenue Service issued Revenue Ruling 56-185 that stated that in order for a hospital to qualify for tax benefits as "charitable",

> ". . . it must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who

> are able and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered."
>
> (Rev. Ruling 56-185, Int. Rev. Bull. 1956)

15. Attempts by private hospitals and/or their agents to have the Internal Revenue Code of 1954 amended to give special tax exempt status to hospitals without regard to free service to persons unable to pay have been rejected by Congress. A recent attempt occurred during the consideration of the Tax Reform Act of 1969. A provision which would have conferred upon hospitals tax exempt status without regard to "charitable" service was set forth in the House bill forwarded to the Senate in August 1969, but the Senate Finance Committee rejected the provision, indicating that it wanted to study the issue in context of its review of the Medicare (42 U.S.C. 1395) and Medicaid (42 U.S.C. 1396) programs. The House bill was conformed to the Senate bill, with the provision deleted, in conference in December 1969. The Tax Reform Act of 1969 was promulgated without such a provision.

16. While the Senate Finance Committee was still considering the issue, the then-Commissioner of Internal Revenue, on October 8, 1969, without a notice of proposed regulations, without a public hearing, and without congressional approval, engaged in legislative action and reversed the historically consistent and lawful interpretation of the word "charitable" in the Internal Revenue Code and issue a ruling that hereinafter the Internal Revenue Service would grant the benefits of the tax exempt provision of the Code to hospitals although said hospitals required that all persons as a condition of admission must be able to pay the cost either directly or through third party reimbursement for hospital services. (Rev. Ruling 69-545, 1969 Cum. Bull.). Despite the subsequent Senatorial disapproval and deletion from the Tax Reform Act of 1969, the DEFENDANTS have not reverted to the historically accepted position.

17. On information and belief throughout the United States private hospitals have been given and continue to receive and enjoy tax exempt status and other benefits under the charitable tax provisions of the Internal Revenue Code of 1954 although they refuse to admit and give services to indigent and medically indigent persons in need of hospital care, and/or admit and thereafter sue and garnish wages of indigent and medically indigent persons in need of hospital care, and/or require either private health insurance or cash deposits as a condition of admission, and/or refuse to admit without a cash deposit patients eligible for Medicaid (governmental health program for public assistance recipients and categorically related persons, 42 U.S.C. § 1396).

18. Persons who are members of and are represented by the organization PLAINTIFFS, and individual PLAINTIFFS and the class they represent, need hospital services but reside in communities in which the private hospitals engage in the practices described in

paragraph 17 herein, and thereby are denied services at said private hospitals which receive and enjoy tax exempt status and other benefits under the charitable tax provisions of the Internal Revenue Code of 1954. The circumstances described in paragraphs 19, 20, and 21 herein documents these practices and the results of these practices.

19. (a) Individual PLAINTIFFS ROSEZELLA COOK, MONICA HUNTER, and SHIRLEY LAMPTON are residents of New Orleans, Louisiana.

(b) PLAINTIFF COOK is a 34 year old Mother of six minor children. The family's sole support is represented by a $73 monthly public assistance check; public assistance also pays $160 a month for a full time housekeeper since PLAINTIFF COOK is too ill to take care of her house and children and needs full time care herself. In June 1970, PLAINTIFF COOK attempted to be admitted to METHODIST HOSPITAL, in New Orleans, but was denied admission because she did not have money needed as a deposit before examination and METHODIST HOSPITAL does not participate in the Medicaid program for which PLAINTIFF COOK is eligible. On various occasions during the following months, specifically September, October, and November, 1970, PLAINTIFF COOK attempted to get admitted at CHARITY HOSPITAL OF LOUISIANA AT NEW ORLEANS (hereinafter CHARITY HOSPITAL), but because of lack of available beds, PLAINTIFF COOK was given only outpatient treatment although a resident on the CHARITY HOSPITAL staff recommended that her medical condition necessitated inpatient treatment. Not until February 1971 was PLAINTIFF COOK admitted for treatment, for the same condition and with the same symptons existing since July 1970.

(c) PLAINTIFF HUNTER is a widow, with four minor children. Her sole monthly income is $147, primarily from Social Security Survivor Benefits. Her income is presently "too high" to qualify her for public assistance, and consequently for Medicaid, under the Louisiana public assistance program. In June 1970, PLAINTIFF HUNTER attempted to get examined and treated at METHODIST HOSPITAL and at HOTEL DIEU HOSPITAL in New Orleans, but at both hospitals was denied examination and treatment for the stated reasons that the hospitals only treated "private patients", that she lacked the money for a deposit, and that the hospitals would not recognize Medicaid under which she was then eligible. Her outpatient treatment at CHARITY HOSPITAL has not relieved her pains, and she believes that she needs extensive tests to determine her condition and the appropriate treatment.

(d) PLAINTIFF LAMPTON is a 30 year old Mother of seven children; the sole family income is derived from a $137 monthly payment under public assistance. She is eligible for coverage under the Medicaid program. In December 1965-January 1966, she was diagnosed at CHARITY HOSPITAL as having kidney problems, but was not admitted as an inpatient. In February 1966, the condition was diagnosed at CHARITY HOSPITAL as having caused permanent damage to her kidneys. Her kidney ailments have persisted until this time. In July 1970, suffering from abdominal pains she went to CHARITY HOSPITAL on two occasions, on the second of which she was given some drugs. She was not admitted as an inpatient. She then went to MERCY HOSPITAL in New Orleans to seek an examination and treatment for her condition. She was told that she needed a private physician, but if she had sufficient money, a physician would be called for her. MERCY HOSPITAL does not participate in the Medicaid pro-

gram. Being without money she left MERCY HOSPITAL. She has continued to suffer pains and swelling in her abdominal area.

(c) CLIFFORD BREAUX was a 57 year old resident of New Orleans who died of congestive heart failure on June 24, 1970. On or about May 1, 1970, a staff physician of OCHSNER FOUNDATION HOSPITAL, who was BREAUX's private physician, examined him and recommended him for hospital admission, but noted that he did not have the $200 for admission into OCHSNER FOUNDATION HOSPITAL and stated he would recommend his admission into CHARITY HOSPITAL. On five occasions between early May and June 8, 1970 CLIFFORD BREAUX and his family attempted to get him admitted into CHARITY HOSPITAL but were unsuccessful because of lack of available beds. On May 29 the intern on the Admit desk recommended his immediate admission but he was not admitted. On June 10 and June 11 his family attempted to obtain admittance for him at OCHSNER FOUNDATION HOSPITAL, TOURO INFIRMARY, and FLINT GOODRIDGE HOSPITAL of DILLARD UNIVERSITY, but was told by staff physician or admitting personnel that they needed to pay a deposit to be admitted. On June 11 his family borrowed $200 and he was admitted into OCHSNER FOUNDATION HOSPITAL upon the payment of the $200 as a deposit. He died in OCHSNER, 13 days after admission, and more than seven weeks after an OCHSNER staff physician had first recorded his need for immediate hospitalization.

(f) METHODIST HOSPITAL, HOTEL DIEU HOSPITAL, MERCY HOSPITAL, OCHSNER FOUNDATION HOSPITAL, TOURO INFIRMARY, and FLINT GOODRIDGE HOSPITAL of DILLARD UNIVERSITY are private nonprofit hospitals in New Orleans which require deposits ranging from $35 for outpatient treat-

ment through $200 to $400 for inpatient treatment prior to admission, and do not participate in the Medicaid program; these hospitals refuse to examine, admit, and/or treat indigent persons seeking hospital services. These practices are common among the private, nonprofit hospitals in the metropolitan New Orleans area.

FLINT GOODRIDGE HOSPITAL of DILLARD UNIVERSITY and one other private nonprofit New Orleans hospital, SARA MAYO HOSPITAL, which claim that they maintained outpatient clinics for medically indigent persons prior to 1970, closed such clinics in early 1970 (shortly after the issuance of Revenue Ruling 69-545); these hospitals also do not participate in the Medicaid program.

TOURO INFIRMARY maintains a reduced-cost clinic for the medically indigent, but persons below a certain income, which corresponds approximately with the OEO poverty guidelines, are not eligible. These private nonprofit hospitals enjoy tax exempt status as determined by DEFENDANTS under Section 501(c)(3) of the Internal Revenue Code of 1954, and substantial donations to these hospitals for the construction of new facilities have been deducted by donors, and further donations shall be deducted. On information and belief such donations have and shall amount to several million dollars.

20. (a) Individual PLAINTIFFS HENRY AND CAROLYN BLOCK are residents of Tucson, Arizona, and are the parents of three young children (ages six, four and five months). The total income for the family of five persons is approximately $200 a month (which is below the poverty guidelines) and is derived from the earnings of PLAINTIFF HENRY BLOCK who works at property maintenance, gardening and general repair services. They do not have the means to pay for medical and hospital services, and are ineligible for County Assistance for medical care. Arizona does not participate in the Federal Medicaid program.

(b) PLAINTIFFS CAROLYN AND HENRY BLOCK owe $88 to TUCSON MEDICAL CENTER as a result of emergency medical care rendered to their youngest child and to PLAINTIFF CAROLYN BLOCK. At the time the emergency care was rendered, TUCSON MEDICAL CENTER was aware of their indigency status. Nevertheless, TUCSON MEDICAL CENTER has referred the bill to a collection agency which is now threatening to sue PLAINTIFFS CAROLYN AND HENRY BLOCK.

(c) TUCSON MEDICAL CENTER is a private nonprofit hospital in Tucson, Arizona, which required preadmission deposits and full payment for all persons not covered by private insurance. If an indigent person applies for non-emergency admission, he is not admitted but is referred to the County Hospital. If an indigent person is admitted in an emergency, and is not eligible for County assistance and cannot be transferred to the County Hospital, he is billed in full, and his bills are turned over to a collection agency and he is sued.

(d) TUCSON MEDICAL CENTER enjoys tax exempt status as determined by DEFENDANTS under the Internal Revenue Code, and substantial donations to this hospital have been deducted by donors and further donations shall be deducted. On information and belief such donations are considerable.

21. (a) EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION represents poor persons in Floyd and Pike Counties, Kentucky, in confronting the health crisis in those Counties, including the problems of poor persons in obtaining hospital care and services. PRESTONBURG GENERAL HOSPITAL and PIKES-

VILLE METHODIST HOSPITAL are private, nonprofit hospitals in Floyd and Pike Counties respectfully, which refuse to admit and treat poor persons who are not covered by private health insurance and lack the means to pay pre-admission deposits. These hospitals refuse admission to poor persons covered by Medicaid if such persons cannot pay said pre-admission deposits.

(b) PLAINTIFF JOEY JAY BLEVINS, is a male child who resides with his parents and guardians MARY AND JAY BLEVINS in Honaker, Kentucky. In the fall of 1967, while the BLEVINS family was without income, JOEY JAY BLEVINS, who was then five years old, suffered a broken leg in a fall. MARY AND JAY BLEVINS, after experiencing difficulty in arranging transportation, took JOEY to the emergency room of the PRESTONBURG GENERAL HOSPITAL. Two doctors examined the leg and informed the PLAINTIFFS that it was broken. After waiting two hours JAY BLEVINS inquired whether his son was going to be treated and was informed that the boy could be treated at the Hospital only if the Hospital would be paid for such treatment immediately. Having no money, MARY AND JAY BLEVINS arranged for transportation of their son to Lexington, Kentucky, 120 miles distant, where his leg was treated at the UNIVERSITY HOSPITAL. JOEY JAY BLEVINS was without treatment for 24 hours. PRESTONBURG GENERAL HOSPITAL has continued to engaged in similar refusals to treat poor people since that time.

(c) PLAINTIFF ARTIE TACKETT is the mother of 14 children whose family's monthly income is $242.00 by reason of her husband's participation in the Mainstream Program operated by the Department of Labor. In January 1971, PLAINTIFF TACKETT was suffering from severe abdominal pain and sought to be examined and treated at the PRESTONBURG GENERAL HOS-

PITAL. PLAINTIFF TACKETT was denied treatment because she was unable to pay the required advance fee.

(d) PLAINTIFF TORA MAE COLLINS is a resident of Tram, Kentucky and the Mother of one child. She and her husband have no income but are recipients of medical assistance (Medicaid). In April 1971, PLAINTIFF COLLINS was eight months pregnant and suffering from severe pain. She sought to be examined and treated at the PRESTONBURG GENERAL HOSPITAL and to make arrangements for the delivery of her baby. PLAINTIFF COLLINS was informed by a physician at the PRESTONBURG GENERAL HOSPITAL that she could not be admitted for the delivery of her baby if she did not have $90.00 in addition to her medical card (Medicaid). PLAINTIFF COLLINS was not examined by the physician despite her pain.

(e) PLAINTIFF BALLARD CABLE is 57 years old and a disabled coal miner. He is the father of three children and his family's sole income is $161.00 a month from public assistance. In December 1970, PLAINTIFF CABLE was suffering from a severe skin disorder and after examination by his physician, PLAINTIFF CABLE attempted to be admitted to the PRESTONBURG GENERAL HOSPITAL. At the admissions desk, PLAINTIFF CABLE presented his medical card (Medicaid) but was informed that there were not beds available. Moments later two people, a nurse and a relative of PLAINTIFF CABLE, both of whom had just come from the inpatient section of the hospital, informed PLAINTIFF CABLE that there were "plenty of empty beds." By reason of this denial, PLAINTIFF CABLE was not hospitalized for several days and only then after traveling 120 miles.

(f) PLAINTIFF VIRGINIA STEPHENS is 30 years old, the Mother of four children and a resident of Harold,

Kentucky. Her husband is unemployed and her family is presently without income. PLAINTIFF STEPHENS is pregnant and has been treated by a physician affiliated with the PRESTONBURG GENERAL HOSPITAL. He informed PLAINTIFF STEPHENS that unless she was able to pay the present bill ($127) owing for his services, he would stop treating her and she would not be admitted to the PRESTONBURG GENERAL HOSPITAL for the delivery of her baby. Unable to pay the outstanding bill, PLAINTIFF STEPHENS sought treatment from a physician in Pikesville, Kentucky. In June 1971, PLAINTIFF STEPHENS was informed she would not be admitted to the PIKESVILLE METHODIST HOSPITAL for the delivery of her baby unless she had $130.00.

(g) On or about June 25, 1971, representatives of the EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION met with the Administrator of the PIKESVILLE METHODIST HOSPITAL to discuss hospital admission policy. He informed the representatives of EKWRO that the PIKESVILLE METHODIST HOSPITAL "treat(s) Floyd County people just like Pike County people—if they don't have money, they don't get in."

(h) PRESTONBURG GENERAL HOSPITAL and PIKESVILLE METHODIST HOSPITAL enjoy tax exempt status as determined by DEFENDANTS under the Internal Revenue Code, and substantial donations, including donations for construction of new facilities, have been and shall be deducted by donors. On information and belief such donations are considerable.

22. On information and belief, there are approximately 40 million persons in the United States who are not covered by private health insurance, the vast majority of whom have resources which place them below

the official poverty guidelines of the U.S. Department of Labor and Office of Economic Opportunity. The individual PLAINTIFFS, and persons who are members of the organizational PLAINTIFFS, are representative of these persons who lack the means to pay for and/or be admitted into private, nonprofit hospitals which enjoy tax exempt status and the benefits of other provisions of the Internal Revenue Code of 1954 as "charitable" organizations.

23. By granting federal tax benefits to private hospitals which exclude all persons unable to pay for services and/or persons whose bills are payable under the Medicaid program and/or admitting as emergencies and thereafter suing for collection of bills persons with incomes too low to pay for medical services, the DEFENDANTS have encouraged and are encouraging such hospitals to deny their services to individual PLAINTIFFS and the class to which they belong, and to members of the organization PLAINTIFFS and persons they represent.

24. As a result of the action of DEFENDANTS, individual PLAINTIFFS and the class to which they belong, and members of organization PLAINTIFFS and persons they represent, have suffered and will continue to suffer injury in their opportunity and ability to receive hospital services in nonprofit hospitals which receive the benefits of tax exempt status and the benefits of other provisions of the Internal Revenue Code of 1954 as "charitable" organizations, and will suffer irreparable harm and the threat of irreparable harm.

CAUSES OF ACTION

25. DEFENDANTS, in granting tax exempt status under Section 501(c)(3) to private hospitals which deny admission and services to all persons who cannot pay, have violated and continue to violate the Internal Reve-

mue Code of 1954, as such hospitals are not organized and operated for charitable purposes, or any other purpose conferring tax exempt status, within the meaning of the Internal Revenue Code of 1954.

26. DEFENDANTS, by promulgating a ruling entitling private hospitals which deny admission and services to all persons who cannot pay to tax exempt status under Section 501(c)(3), have engaged in arbitrary and capricious conduct in violation of the Internal Revenue Code.

27. DEFENDANTS, by promulgating a ruling entitling private hospitals which deny admission and services to all persons who cannot pay, without a public hearing and the opportunity for interested and/or affected persons to present their views, arguments and positions, have violated the rule-making procedures required by the Administrative Procedures Act (5 U.S.C. 553).

28. DEFENDANTS, by failing to collect taxes due and owing from private hospitals which deny admission and services to all persons who cannot pay and from donors to such hospitals which have deducted donations to such hospitals from their adjusted gross incomes, have violated and continue to violate the Internal Revenue Code of 1954.

29. DEFENDANTS, by granting federal tax benefits to private hospitals which discriminate against persons unable to pay for medical services and against persons covered by the Medicaid program, have denied to such persons due process of law within the meaning of the Fifth Amendment to the United States Constitution.

RELIEF REQUESTED

WHEREFORE, PLAINTIFFS pray that this Court enter judgment for them and the class they represent as follows:

30. The Court order preliminary relief suspending the grant of tax exempt status to private hospitals which deny admission and services to persons unable to pay until final adjudication of this issue.

31. The Court order that this action be maintained as a class action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure.

32. The Court issue prohibitory and mandatory injunctions directed to DEFENDANTS, their agents, servants, employees, attorneys, and all persons in concert and participation with them:

(a) enjoining them from granting exemption from income taxes to private hospitals pursuant to 501(c)(3) of the Internal Revenue Code of 1954 without requiring said hospitals to serve persons unable to pay and persons covered by Medicaid, without requiring proof that such hospitals do not deny service and otherwise discriminate against persons unable to pay and persons covered by Medicaid, and without requiring proof that such hospitals do not excuse people too poor to pay for the payment of bills for services rendered; from allowing individual and corporate contributors to such hospitals to deduct the contributions from gross income of their income tax returns under 170(a) through (c) of the Internal Revenue Code of 1954; and from allowing such hospitals all other benefits and advantages under 642(c), 2055, 2106(a)(2), and 2522 of the Internal Revenue Code of 1954;

(b) requiring them forthwith to institute proceedings leading to the rescission, withdrawal, and revocation of

approval of applications granting exemption from income taxes under 501(c)(3) of the Internal Revenue Code of 1954 from private hospitals which do not serve persons unable to pay and persons covered by Medicaid; allowing individual and corporate contributors to such hospitals to deduct the contributions from gross income on their income tax returns under 170(a) through (c) of the Internal Revenue Code of 1954, and allowing such hospitals all other benefits and advantages under 642(c), 2055, 2106(a)(2), and 2522 of the Internal Revenue Code of 1954;

(c) requiring all private hospitals which desire to attain or retain "charitable" tax status and eligibility for the benefits of Sections 501(c)(3), 170(a) through (c) and 642(c), 2055, 2106(a)(2), and 2522 of the Internal Revenue Code of 1954, to file specific data, on forms devised by the DEFENDANTS or their agents, and approved by this Court, for said purpose, verifying that said hospitals do afford service to persons unable to pay, do not discriminate against persons covered by Medicaid, do not require a deposit as a condition for admission for all persons not covered by private health insurance, and do not attempt to collect payment for persons determined to be too poor to pay for services;

(d) ordering them to collect all taxes due and owing because of the illegal designation of "charitable" to hospitals which do not serve persons unable to pay and persons covered by the Medicaid program.

33. The Court declare that in order for hospitals to qualify for the status of "charitable" within the meaning of the Internal Revenue Code of 1954, that such hospitals must not discriminate against and deny service to persons unable to pay and to persons covered by the Medicaid program.

34. The Court declare that the Commissioner of Internal Revenue lacked the legal authority to grant tax exempt status to hospitals which do not serve persons unable to pay.

35. The Court declare that the Commissioner of Internal Revenue lacked the legal authority to promulgate Revenue Ruling 69-545 without following the rule-making procedures of the Administrative Procedure Act.

36. The Court grant PLAINTIFFS such further and additional relief as this Court deems equitable, just, and proper.

Respectfully submitted,

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(304) 344-9687

DATED: July 12, 1971

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

[Title Omitted]

MOTION TO DISMISS

[Filed Nov. 18, 1971]

Defendants, John B. Connally, Jr., Secretary of the Treasury of the United States, and Johnnie M. Walters, Commissioner of Internal Revenue, move this Court, pursuant to Rule 12 of the Federal Rules of Civil Procedure, for the entry of an order dismissing plaintiffs' complaint on the grounds that:

1. This Court has no authority to grant the relief requested because the provisions of 28 U.S.C., Section 2201 forbid the granting of a declaratory judgment with respect to Federal taxes.

2. Under the provisions of Section 7421(a) of the Internal Revenue Code of 1954 (26 U.S.C.) this Court has no jurisdiction to enjoin the assessment and collection of Federal taxes.

3. This Court has no jurisdiction over the subject matter of this action because:

(a) The matters complained of do not present a justiciable case or controversy within the meaning of Article III of the Constitution of the United States, and are not otherwise justiciable, and

(b) No one of the plaintiffs has standing to maintain this action.

4. This Court does not have jurisdiction over the persons of the defendants, inasmuch as the suit is, in fact,

one against the United States, and, as such, is barred by sovereign immunity.

5. The complaint fails to state a claim upon which relief can be granted.

/s/ John J. McCarthy
JOHN J. MCCARTHY
Chief
General Litigation Section

/s/ George F. Lynch
GEORGE F. LYNCH
Assistant Chief
General Litigation Section

/s/ Jack B. Teplitz
JACK B. TEPLITZ
Trial Attorney,
Tax Division
Department of Justice
Washington, D.C. 20530

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 1370-71

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, et al., PLAINTIFFS

vs.

JOHN B. CONNALLY, JR., as Secretary of the Treasury of the United States, et al., DEFENDANTS

ORDER

[Filed May 10, 1972]

The defendants having moved for an order dismissing the complaint herein, on the grounds: that this Court has no authority to grant declaratory relief in the instant proceeding because 28 U.S.C. 2201 forbids the granting of said relief with respect to Federal taxes; that this Court has no jurisdiction to issue injunctive relief by virtue of the provisions of 26 U.S.C. 7421(a) forbiding the enjoining of the assessment and collection of taxes; that this Court has no jurisdiction over the subject matter because the matters complained of do not present a justiciable case or controversy and the plaintiffs have no standing to maintain this action; that the suit is barred by sovereign immunity; and that the complaint fails to state a claim upon which relief can be granted,

Now, after consideration of the motion, the opposition thereto, the pleadings, and argument of counsel, it is by the Court this 10th day of May, 1972

ORDERED, that the said motion be denied in all respects.

/s/ Barrington D. Parker
U.S. Federal Judge

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

[Title Omitted]

MOTION FOR SUMMARY JUDGMENT
AGAINST DEFENDANTS

[Filed April 10, 1973]

Plaintiffs move this Court to enter, pursuant to Rule 56 of the Federal Rules of Civil Procedure, a Summary Judgment in Plaintiffs' favor against the Defendants, declaring that granting tax exempt status to hospitals as "charitable" institutions, and permitting donors to deduct from their income tax contributions to such institutions, without requiring said hospitals to admit and provide free services to persons unable to pay, violates the Internal Revenue Code (26 U.S.C. 501(c)(3) and 170(a) through (c)), that the procedures under which such policy was promulgated violates the Administrative Procedures Act (5 U.S.C. 553 and 706(A)(2)) and the due process clause of the Fifth Amendment, that such practices are hereby restrained and enjoined, and that Defendants are charged to rescind said ruling and to collect all taxes due and owing because of such illegal actions.

This Motion is based upon the following:

(a) the pleadings;

(b) the Affidavits from Individual and Organizational Plaintiffs;

(c) STATEMENT OF ORGANIZATIONS AND INDIVIDUALS REPRESENTING INDIGENT AND MEDICALLY INDIGENT PERSONS CONCERNING THE DEFINITION OF "CHARITABLE" HOSPITALS UNDER SECTION 170 OF THE INTERNAL REVENUE

CODE, with attachments and Affidavit of Anthony Z. Roisman;

(d) Statement of Material Facts Not in Dispute;

(e) Memorandum of Points and Authorities in Support of Motion.

Plaintiffs also refer to Affidavits submitted in the case of *Cook et al* vs. *Ochsner Foundation Hospital et al*, Civ. Act. No. 70-1969, E.D. La., copies of which are attached hereto.

DATE: April 10, 1973

Respectfully submitted,

/s/ Marilyn G. Rose
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INDEX OF EXHIBITS

Exhibit 1	Xerox pages of chapter 4, Report of the Staff to the Senate Committee on Finance, 91st Cong., 1st Session, Feb. 9, 1970.
Exhibit 2	Statement of organizations and individuals representing indigent and medically indigent persons with attachments to Commissioner of Internal Revenue, June 18, 1971.
Exhibit 3	Affidavit of Anthony Z. Roisman
Exhibit 4	Affidavit of Eula Hall, Chairman, Health Committee, Eastern Kentucky Welfare Rights Organization
Exhibit 5	Affidavit of Artie and Clarence Tackett
Exhibit 6	Affidavit of Tora Mae Collins
Exhibit 7	Affidavit of Lards Collins
Exhibit 8	Affidavit of Carolyn Block
Exhibit 9	Affidavit of Howard Linville, Treasurer, Association of Disabled Miners and Widows
Exhibit 10	Affidavit of Rosezella Cook
Exhibit 11	Affidavit of Monica Hunter
Exhibit 12	..... (reserved number of Affidavit of National Tenants Organization)
Exhibit 13	Affidavit of Rachel Miller, President, California Welfare Rights Organization
Exhibit 14	Affidavit of Marilyn G. Rose, to which are attached copies of Affidavits in the case of *Cook et al.* vs. *Ochsner Foundation Hospital et al.*, Civ. Act. No. 70-1969, E.D. La.
Exhibit 15	Letter of Rosemarie Shomstein, Senior Research Assistant of Health Insurance Institute

EXHIBIT 1

91st Congress
1st Session

COMMITTEE PRINT

MEDICARE AND MEDICAID

Problems, Issues, and Alternatives

REPORT OF THE STAFF

TO THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

RUSSELL B. LONG, *Chairman*

[SEAL]

FEBRUARY 9, 1970

Printed for the use of the Committee on Finance

CHAPTER FOUR

TAX-EXEMPT STATUS OF COMMUNITY HOSPITALS AND OBLIGATION TO PROVIDE CHARITABLE CARE

The staff believes the committee's attention should again be called to the potential cost implications for medicare, medicaid, and other public programs of Internal Revenue Service Ruling 69-545, announced on October 8, 1969. That ruling overturns earlier IRS decisions that a hospital, in order to qualify for tax exemption under section 501(c)(3) of the Internal Revenue Code must provide charitable or below-cost care to the extent of its financial ability.

The tax reform bill passed by the House of Representatives (H.R. 13270) also contained a provision which removed the charitable or below-cost care requirement as a condition of tax exemption for hospitals. Ruling 69-545 was issued subsequent to House passage of the tax bill. On October 28, 1969, the Finance Committee deleted the provision contained in the House bill, indicating that it desired to consider the question in the context of medicare and medicaid. The committee action was approved by the Senate and accepted by the House.

Prior to consideration of the House bill in the Senate, the Committee on Finance instructed the staff to summarize the various provisions in the bill and to describe the major arguments for and against the amendments contained in the bill. Insofar as this hospital amendment was concerned, this "Summary of H.R. 13270, the Tax Reform Act of 1969 (as passed by the House of Representatives), August 18, 1969," stated as follows:

11. *Hospitals*

Present law.—Hospitals qualify for exempt status and may receive deductible charitable contributions as "charitable" organizations.

Problem.—It has been contended by some agents that hospitals (unlike educational organizations, churches, and others) must provide some significant amount of charitable services on a no cost or loss basis in order to be exempt as "charitable" organizations.

House solution.—The bill provides that hospitals are to have the same status as churches and educational institutions for purposes of tax exemption, charitable contributions, and a variety of other matters. The other requirements for exemption—no inurement of profits to private individuals, operation and organization exclusively for exempt purposes, no substantial legislative activities, and no political electioneering activities—continue to apply to hospitals.

Arguments For.—(1) These provisions are necessary to eliminate challenges to the tax-exempt status of hospitals on the ground that the hospitals are accepting insufficient numbers of patients at no charge or at rates that are substantially below cost.

(2) By establishing hospitals as a separate exempt category and removing the indefinite test of to what extent a hospital must serve those who cannot pay, this bill removes the uncertainty surrounding the hospital's continued ability to draw necessary support from the public or from private foundations to accomplish its function.

(3) Hospitals perform a useful function of the sort that deserves treatment in section 501(c)(3) on the same basis as the other organizations specifically named in that provision.

(4) The present environment of governmental assistance to permit medical care to be made available to those otherwise unable to pay, appears to make obsolete the need for hospitals themselves to subsidize the providing of medical care to poor people. This is as true regarding hospitals as it is regarding schools and churches.

Arguments against.—(1) In order to be tax exempt, hospitals historically have been required to render service to the poor whether or not there was an ability to pay for the services rendered. These provisions would do away with that requirement and many marginal income families that are now ineligible for payment of hospital care under Medicaid, and who do not have sufficient resources to pay for hospital treatment might be denied care now available to them. This is especially true in States that do not pay for hospital care of people who are eligible for general assistance under the welfare programs of the State. The bill will pose particular hardships on poor families priced out of hospital care by continually rising health costs and this will put greater pressure on Congress to expand the Medicaid program at the very time Congress is seeking to contract and moderate it.

(2) To the extent hospitals contend Medicare and Medicaid does not pay their full costs they would also contend that they are providing *charitable* services for those patients. If the bill were not changed these hospitals could refuse Medicare and Medicaid patients with impunity or could limit their services to such patients unless the Government met the hospitals' unilateral cost demands. Without the balanc-

ing effect of the present Internal Revenue Service position, government might be faced with the choice of either complying with such payment ultimatums or seeing millions of poor and aged citizens denied necessary care in community nonprofit hospitals.

(3) There is no substantial evidence that contributors to hospitals will decrease or stop their donations because the Internal Revenue Service is questioning the tax-exempt status of a hospital (or hospitals) on the ground that sufficient charitable services are not being rendered to the poor.

(4) The extent of free and "below cost" hospital care has diminished greatly with the advent of public programs such as Medicare and Medicaid. The pressure to provide free care has lessened to the extent that these multi-billion dollar programs and private hospital insurance are now paying for many of those whose bills previously went unpaid.

(5) The bill discards the charitable basis—the "community service to all" concept—on which tax exemption of hospitals is founded.

(6) If there is a legitimate complaint that Internal Revenue rulings are too vague on this point, a clarifying amendment establishing statutory standards is the appropriate remedy rather than the blanket approach of the House provision.

(7) Since the need for new legislative language has arisen because of uncertainties in administration, then the resolution of such uncertainties could be handled on an administrative basis.

The committee will recall the concern over the implications of the House-adopted provision expressed by the National Governors' Conference in the letter addressed to the chairman (reproduced below) and in subsequent

correspondence. Recently in the District of Columbia indigent patients were referred by some nonprofit community hospitals to the publicly operated D.C. General Hospital because of the inability of the District government to pay more than 80 percent of outpatient hospital costs for indigent patients. This situation appears to reinforce the anxiety expressed by the National Governors' Conference. The prior rulings of the Internal Revenue Service provided a measure of protection against any unreasonable refusal by a nonprofit hospital to provide charitable and below-cost care.

NATIONAL GOVERNORS' CONFERENCE,
Washington, D.C., October 27, 1969.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR LONG: I understand that the Senate Finance Committee will soon be considering in Executive Session a section in the Tax Reform Act of 1969 that provides that private, non-profit hospitals can no longer be challenged to defend their tax exempt status in terms of the amount of charitable services they provide. This provision, as contained in the House passed bill, HR 13270, and in a recent Internal Revenue Service ruling, could result in hospitals refusing to serve Medicare and Medicaid patients or limiting their services to such patients unless the state meets the hospitals' demands for a certain level of payment.

I urge you, as Chairman of the Senate Finance Committee, to provide in the Tax Reform Act of 1969 for some means for states to control levels of payment to hospitals without endangering the avail-

ability of services for Medicare and Medicaid patients.

States have found it necessary to place some control on levels of payments to providers under the Medicaid program. Unless this control on the costs of Medicaid is maintained, states will be faced with an even greater financial burden under Medicaid, as will the Federal government.

Governors of states that have recent experience with freezing of levels of payment to hospitals and with challenges to the tax exempt status of hospitals will also be contacting you on this matter.

Sincerely,

CHARLES A. BYRLEY.

On the same day on which the Finance Committee deleted the House amendment, October 28, 1969, the American Hospital Association in its formal testimony on medicare before the Committee on Ways and Means included the following statement by Mr. Mark Berke, president-elect of the organization:

> "The institutional health care system differs from the rest of the private sector in its philosophy toward and treatment of patients who are unable and or unwilling to pay. Other members of the private sector maintain their right to not sell their product to someone who cannot afford it or is unwilling to pay for it.
>
> *Community hospitals, because of their public responsibility, do not take such action. The right to receive service regardless of the ability to pay is extended to the entire community,* and consequently the entire community has an obligation to share in these costs." [Emphasis supplied.]

Particular attention is called to the statement that "The right to receive service regardless of the ability to pay is extended to the entire community . . ." If the testimony of the American Hospital Association before the Committee on Ways and Means is a fair and accurate presentation of the hospitals' position, the staff is at a loss to understand why the hospitals sought the House amendment in the first instance.

Furthermore, the staff cannot reconcile that statement of dedication to the poor with the example of a tax-exempt hospital included in Revenue Ruling 69-545:

> "Hospital A is a 250-bed community hospital. Its board of trustees is composed of prominent citizens in the community. . . . The hospital operates a full-time emergency room and no one requiring emergency care is denied treatment. *The hospital otherwise ordinarily limits admissions to those who can pay the cost of their hospitalization. . . . Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community which does serve indigent patients.*
>
> *The hospital usually ends each year with an excess of operating receipts over operating disbursements* from its hospital operations. Excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research." (Emphasis supplied.)

In the Internal Revenue Service example of what it proposes to recognize as a tax-exempt hospital, "The right to receive service regardless of the ability to pay" is clearly *not* extended to the entire community.

The staff strongly recommends revocation of Revenue Ruling 69-545 in light of the recent legislative history

and continuation of the prior position of the Service until such time as Congress can devise an alternative approach establishing reasonable yardsticks of charitable service related to the financial capacity of a hospital. Such action by the Service would assist in protecting the availability of necessary hospital care to Medicare, Medicaid, and other poor patients.

EXHIBIT 2

NATIONAL LEGAL PROGRAM
ON
HEALTH PROBLEMS OF THE POOR

2477 Law Building
405 Hilgard Avenue
Los Angeles, California 90024
(213) 825-7601

June 18, 1971

Commissioner of Internal Revenue
Attention: CC:LR:T
Washington, D.C. 20224

Re: Hearing on Proposed Regulations

Dear Sir:

In accordance with the Notice of Hearing of proposed amendments to the regulations under section 170 (b) (1) (A) of the Internal Revenue Code of 1954, and my letter of June 8, 1971 requesting an opportunity to testify on behalf of the National Legal Program on Health Problems of the Poor and a number of its organizational and individual clients, I have enclosed five (5) copies of our Statement and supporting Documents.

As I mentioned in the letter of June 8, 1971, in view of the fact that a member of our Staff from California shall testify, we would like to be given a specific date and time for appearing. Would you please so inform us at this address, and also inform Mr. Anthony Z. Roisman

(Berlin, Roisman and Kessler, 1910 N. Street, N.W., Washington, D.C. 20036, 833-9070) who shall appear on our behalf.

Sincerely yours,

Marilyn G. Rose
Chief, Special Litigation

MGR/cm
Enclosures
cc: Anthony Roisman
bcc: Lawrence Norton
Jeffrey Schwartz
Peter Sitkin
Daniel Karnes
Peter Axelrod
Bruce Rogow

STATEMENT OF

ORGANIZATIONS AND INDIVIDUALS REPRESENTING INDIGENT AND MEDICALLY INDIGENT PERSONS CONCERNING THE DEFINITION OF "CHARITABLE" HOSPITALS UNDER SECTION 170 OF THE INTERNAL REVENUE CODE

This statement and these documents are submitted by and on behalf of the following organizations and individuals concerning the definition of "charitable" as it pertains to hospitals under Section 170 of the Internal Revenue Code, as amended by the Tax Reform Act of 1969:

NATIONAL LEGAL PROGRAM ON HEALTH PROBLEMS OF THE POOR

By: Laurens H. Silver
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EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION
c/o Mrs. Eula Hall
Chairwoman Health Committee
Craynor, Kentucky

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I. SUMMARY OF STATEMENT

Historically under the Internal Revenue Code hospitals have only been eligible as beneficiaries of tax-deductible contributions if they rendered "charitable" services, i.e. if their facilities were open to all persons in the community including persons unable to pay for services. In 1969 spokesmen for the American Hospital Association sought to have sections 170 and 501(c)(3) amended to provide that hospitals could be eligible for the benefits of said provisions without regard to qualifying as "charitable." The House Ways and Means Committee reported its bill with the amendments sought by the American Hospital Association. These amendments were not acceptable to the Senate Finance Committee, which stated that it desired to consider the issue in context of its study of Medicare and Medicaid. The amendments were deleted from the House bill in Conference and did not become a part of the Tax Reform Act of 1969. Congress then left the law in its "historic" state.

However, in the interim between the House Report and the Senate Report, the Internal Revenue Service issued an informal ruling under the tax exemption provisions of section 501, by which it "reinterpreted" the meaning of the work "charitable" and eliminated the requirement that hospitals must not close their doors to persons unable to pay in order to qualify for tax exempt status. Since that action private hospitals which heretofore gave some charity service have closed down those facilities or otherwise closed their doors to the poor. We believe that such closures, even if not actually caused by the Ruling, have at least encouraged them.

There is a health crisis in this country, and the poor are bearing the brunt of it. Public hospitals are underfinanced, understaffed, underequipped, and inadequate to care for all persons seeking their aid. Private hospitals,

which receive the benefits of the tax provisions for "charitable" organizations, are turning the poor away in a multiple of ways, including: erecting deposit requirements beyond the means of even the average person to pay (but waiving the deposits for those with health insurance), closing their clinics, transferring the poor and the "unacceptable" to the overcrowded public hospitals, refusing to participate in the Medicaid program.

We believe that these factors require the Internal Revenue Service to clarify the standards for hospitals to be eligible for the status of charitable donees of otherwise taxable dollars under section 170 of the Internal Revenue Code by re-establishing and enforcing the historic legal requirements that such hospitals must not close their doors to the poor and that no hospital which refuses to give services to the indigent and medically indigent of its community can be considered a "charitable" hospital. This action is necessitated because of the consequences of the ill-conceived and unwise ruling on tax exempt status of charitable hospitals. As detailed herein, we contend that affording "charitable" status to a hospital under § 170 which refuses to afford services to the poor is: (1) legally infirm and (2) is unwise and poorly considered policy from a health and social standpoint.

II. THE LEGAL REQUIREMENTS OF THE CHARITABLE STATUS OF HOSPITALS UNDER SECTION 170 OF THE INTERNAL REVENUE CODE

The Internal Revenue Service, just as any other agency of Government, has no power to amend the Statute under which it operates, whether by regulation or by interpretive action. The legislative history of the charitable deduction provision in the Internal Revenue Code, longstanding judicial interpretation of that provision as it

relates to hospitals, and, most especially, the expressed intention of the 91st Congress require that IRS require hospitals to provide services to persons unable to pay in order to be eligible for the tax deduction benefits of the Code, until and unless Congress by appropriate legislation authorizes a different policy.

Admonitions of the Supreme Court to the Internal Revenue Service support this claim that IRS must abide by this legislatively approved interpretation. Thus, in *Fribourg Navigation Co.* v. *C.I.R.*, 383 U.S. 272, 283, the Court stated,

> "Over the same extended period of years during which the foregoing administrative and judicial precedent was accumulating, Congress repeatedly re-enacted the depreciation provision without significant change. Thus beyond the generally understood scope of the depreciation provision itself, the Commissioner's longstanding and consistent administrative practice must be deemed to have received congressional approval."

In *United States* v. *Leslie Salt Co.*, 350 U.S. 383, 396-7, the Court said,

> "Against the Treasury's prior longstanding and consistent administrative interpretation its more recent *ad hoc* contention as to how the statute should be construed cannot stand. Moreover, the original interpretation has had both express and implied congressional acquiescence, through the 1918 amendment to the statute . . . which has ever since continued in effect, and through Congress having let the administrative interpretation remain undisturbed for so many years. [cite]"

(A) *The Legislative History of the Charitable Tax Deduction Provision Requires Hospitals to Serve Persons Unable to Pay.*

The origin of the provisions dealing with tax deduction and tax exemption under the Internal Revenue Code stems from section 32 of the Act of August 27, 1894, which exempted from taxation "corporations, companies or associations organized and conducted solely for charitable, religious, or educational purposes." Although the legislative history for inclusions is scant (the focus of congressional debate being the value of a tax on incomes vis-a-vis a tariff on imports), the inclusion of a specific exempt classification for hospitals apart from charities would not have been novel if the sponsors of the legislation so desired. In England it was reported that exemptions extended to "charities, universities, friendly, industrial, and provident societies, hospitals, etc. . . ." (Cong. Rec., Vol. 26, 53rd Cong., pp. 584, 586, Jan. 9, 1894). It could also be found in the laws of certain States. E.g., in New York hospitals were an "exempt" classification, provided that they rendered medical care to "poor persons in need of such treatment without charge" (a requirement which was subsequently removed *legislatively*). See *People* v. *Sexton*, 48 N.Y.S. 2d 201, 267 App. Div. 736 (Appellate Division, 1944).

The same provisions with respect to corporations and organizations for "religious, charitable, or educational purposes" were carried into the corporation excise law of 1909 (section 38, Act of August 5, 1909, 36 Stat. 11) and the income tax of 1913 (section II(G)(a), Act of October 3, 1913, 38 Stat. 114). With respect to the act of 1913 it should be noted that while a suggestion of Congressman Rogers to add "scientific" to the list of tax exempt purposes was accepted, his amendment with respect to adding "benevolent" was not accepted (Cong.

Rec., Vol. 50, pp. 1305-1306, 63rd Cong., 1st Sess.). In support of that latter inclusion he had stated,

> ". . . it has been held in Massachusetts that a corporation may be 'charitable' within the meaning of the Statute, without being 'benevolent,' and that it may be 'benevolent' without being 'charitable.' Therefore, in view of the undoubted fact, as I conceive it, that we ought to care not merely for charitable corporations, but also for benevolent corporations, it seems to me clear that this word should be added . . ."

Congress was obviously unwilling to accept such an inclusion.

In 1924 it rejected a more specific suggestion to take "charitable" out of its limiting "relief of the poor" context. Thus when Senator Willis of Ohio proposed to add to the predecessor provision of section 170 parenthetical language after "charitable" so as to define that term to include "preventive and constructive service for relief, rehabilitation, *health*, character building, and citizenship," the sentiment was expressed in the Senate that such terms were too elastic and that Congress had gone as far as it should go with the revenues of Government. (Cong. Rec., Vol. 65, pp. 8171-8173, 68th Cong., 1st Sess.). Senator Willis had predicated the need for his amendment to reverse a 1923 Ruling [1] of the-then Commissioner of IRS "that gifts to financial federations doing welfare work and social service other than *relief to the poor* would not be among the allowable deductions." The effect of this purposeful refusal to broaden the scope of "charitable" beyond this 1923 Ruling and to include broad

[1] In Revenue Ruling II-27-1128, I.T. 1800, Int. Rev. Bull. II-1-2 (1923), p. 152-153, IRS contrasted "charitable" used in the broad sense for trust purposes and "charitable" used in its popular and ordinary sense pertaining to "relief of the poor," and held that the latter was the intent of Congress for internal revenue purposes.

social welfare purposes (including health) was to place the Congressional stamp of approval on the concept that charitable for tax purposes was to remain focused on the relief of the poor.

The tax deduction provision of the Internal Revenue Code defining "charitable" has remained the same in the intervening years.

In 1969 the American Hospital Association (hereinafter AHA) attempted to obtain exempt status and tax deduction eligibility for hospitals under sections 501(c)(3) and 170, without regard to service to persons unable to pay. It sought to obtain such benefits by means of amendments to the Internal Revenue Code, and witnesses appeared in support of such propositions before the House Ways and Means Committee in February 1969 (Hearings before the Committee on Ways and Means, House of Representatives, Tax Reform 1969, 91st Cong., 1st Sess., Part 4 (February 26, 1969), 1425). The position of the AHA was directed toward an advancement of the proposition that the mere existence of a nonprofit hospital facility whose purpose is the advancement of health is charitable *per se* (Ibid, at 1428, 1433).

Congressman Gibbons of Florida questioned the AHA spokesmen about the effect of removing the tax exempt status requirement of service to the poor. Despite their protestations that voluntary hospitals carried "a public trust," he voiced skepticism about hospital beneficence if the coercive pressure to serve the poor was removed (Ibid at pp. 1440-1441).

No one testified on behalf of the poor, and no reference was made to the inadequacies of the present system to deal with their hospital needs. The House Bill, as reported in August 1969, contained provisions which added "hospitals" to the list of organizations to which 170 "charitable" contributions could be made (House Report

on Tax Reform Act of 1969, 91st Cong., 1st Sess., U.S. Code Congressional and Administrative News, p. 1688). The rationale in the House Report for the admendment to the Code was basically one proffered by the AHA, i.e. that the present enforcement of the law "has resulted in significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status."

However, the House Amendment was struck from the provision in the Senate Bill, and the Conference version (and the ultimate Act as it became law in Dec. 1969) followed the Senate version. (Conference Report on Tax Reform Act of 1969, 91st Cong., 1st Sess., U.S. Code Cong., & Admin. News, p. 2404). There exists a quite detailed history for the Senate deletion of the House amendment in the Report of the Staff of the Senate Finance Committee, to the Committee, issued in February 1970. (*Medicare and Medicaid, Problems, Issues, and Alternatives*, Report of the Staff to the Committee on Finance, Senate, 91st Cong., 1st Sess., pp. 55-58). Included in that history is a letter to the Senate Finance Committee from the National Governors' Conference opposing the amendment:

> "I understand that the Senate Finance Committee will soon be considering in Executive Session a section in the Tax Reform Act of 1969 that provides that private, nonprofit hospitals can no longer be challenged to defend their tax exempt status in terms of the amount of charitable services they provide. This provision, as contained in the House passed bill, H.R. 13270, and in a recent Internal Revenue Service ruling, could result in hospitals refusing to serve Medicare and Medicaid patients or limiting their services to such patients unless the state meets the hospitals' demands for a certain level

> of payment. I urge you, as Chairman of the Senate Finance Committee, to provide in the Tax Reform Act of 1969 for some means for states to control levels of payment to hospitals without endangering the availability of services for Medicare and Medicaid patients.
>
> "States have found it necessary to place some control on levels of payments to providers under the Medicaid program. Unless this control on the costs of Medicaid is maintained, states will be faced with an even greater financial burden under Medicaid, as will the Federal Government."

The Staff had earlier prepared arguments in support of and against the amendments. The major thrust of its arguments for the amendments related to the "obsolete" nature of the requirement in view of Government funded health programs; the major thrust of its arguments against the amendment related to the impact on poor people ineligible for hospital coverage under the Medicaid program and on the costs to Government forced to increase the payment and coverage under Medicare and Medicaid or faced with the possibility of "seeing millions of poor and aged citizens denied necessary care in community nonprofit hospitals."

Apparently the pleas concerning the impact of Medicare and Medicaid had their effect, for the Senate deleted the provision from the bill "indicating that it desired to consider the question in the context of Medicare and Medicaid." As noted, the Tax Reform Act of 1969 was enacted without the House amendment permitting hospitals tax exempt and tax deductible status without requiring care to persons unable to pay.

Congress clearly did not intend that IRS should grant hospitals tax deductible status without regard to service to the poor, until and unless Congress decided the issue.

However, the uncertain state of affairs created by Revenue Ruling 69-545 on tax-exemption requires that IRS clarify the issue and "restore" the prior legal position, which most appropriately can be done by regulations under section 170.

(B) *Decisions of the Tax and Federal Courts Require that Hospitals Serve the Poor in Order to Be Eligible for Status as "Charitable" Institutions.*

Revenue Ruling 56-185 set forth the basic historic position of the Courts and IRS as to the requirements for hospitals to be eligible for charitable status under both 501(c)(3) and 170. (1956-1 Cum. Bul. 202). To the extent pertinent hereto, that Ruling specifically required that a qualifying hospital:

". . . must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered."

In numerous cases through the years the Tax and Federal Courts have taken that position. See *C.I.R.* v. *Battle Creek Sanitarium*, 126 F.2d 405 (C.A. 5, 1942); *Intercity Hospital Ass'n* v. *Squire*, 56 F. Supp. 472 (W.D. Wash., 1944); *Davis Hospital Inc.* CCH Dec. 14,456 (M), 4 TCM 312, March 14, 1945; *Goldsby King Memorial Hospital*, CCH, Dec. 14,042 (M), 3 TCM 693, July 19, 1944; *Robert C. Olney*, CCH Dec. 23,265 (M), 17 TCM 982, Nov. 28, 1958; *John J. Cranley, Jr.*, CCH Dec. 24,609 (M), 20 TCM 20, Jan. 18, 1961; *Sonora Community Hospital*, 46 T.C. 519 (1966); *Lorain Avenue Clinic*, 31 T.C. 141 (1958). Cf. *Hassett* v. *Associated Hospital Service Corporation*, 125 F.2d 611 (C.A. L, 1942).

Thus in *Battle Creek* the Fifth Circuit stated,

"It is also usual for hospitals and sanitariums to charge those able to pay for services rendered, in order to pay for the expenses of the institution, while not denying treatment to others unable to pay anything. Such institutions are classed as charitable." (At 406).

The Tax Court followed this position in *Davis Hospital*, *supra*, and *Goldsby Memorial*, *supra*, during the same mid-1940's period. More recently, in 1966 in *Sonora Community Hospital*, *supra*, the Tax Court rejected the notion that hospital care *per se* is charitable, stating,

"The mere fact that petitioner maintained a hospital does not in and of itself justify the conclusion that it was operated exclusively for charitable purposes. While the diagnosis and cure of diseases are indeed purposes that may furnish the foundation for characterizing an activity as 'charitable,' something more is required" (At 525-526).

Back in 1942 the First Circuit too had rejected the notion that the nonprofit dedication to health was *per se*

entitled to tax benefits as charitable (See *Hassett* v. *Associated Hospital Service Corporation*, 125 F.2d 611).

In the Ruling reversing the requirements for tax exempt hospitals, and permitting such exemption despite no care to the poor, IRS relies solely upon the authority of Scott, in his treatise on Trusts and in the Restatement of Trusts (of which he is the principal reporter) that:

> ". . . the promotion of health . . . is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit does not include all members of the community such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community." (Revenue Ruling 69-545, 1969, Int. Rev. Bull. No. 44)

The misplaced reliance upon this authority shall be discussed *infra*, in context of the discussion on policy considerations. However, even assuming the policy considerations are the same for tax purposes as for trust purposes, the status of an organization to receive benefits under the Internal Revenue Code exist purely by that Statute. The legislative history, most particularly that in 1924 and in 1969, and the historic judicial interpretation of the meaning of "charitable" as it pertains to hospitals under the Internal Revenue Code, require IRS not to permit taxpayers to take as charitable deductions contributions to hospitals which "refuse to accept patients in need of hospital care who cannot pay for such services."

III. The Policy Considerations for Requiring that Private Hospitals Furnish Services to Persons Unable to Pay

The Staff Report to the Senate Finance Committee, in the subpart dealing with the obligation of community hospitals to provide charitable service under the Internal Revenue Code, concludes with the recommendation that the Revenue Ruling dealing with tax exempt status of hospitals which do not serve the poor be revoked "in light of the recent legislative history and continuation of the prior position . . . [s]uch action by the Service would assist in protecting the availability of necessary hospital care to Medicare, Medicaid, and other poor patients." This recommendation should be followed also in regard to the eligibility of hospitals to receive tax-deductible contributions. Aside from the legal requirements, the policy considerations underlying the grant of tax benefits to hospitals militate a requirement that the indirect subsidization of hospitals through the tax deduction provisions of the Internal Revenue Code[2] be only given to such hospitals as are open to all persons in the community, including persons unable to pay.

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[2] Cf. *Green* v. *Kennedy*, 309 F. Supp. 1127 (1970) that tax benefits under the Code operate not too unlike a grant-in-aid, and that contributions to institutions eligible for status under the tax benefits provisions of the Code encourage contributions. Such indirect subsidization can be considerable. For example, in fiscal year 1969, some $22.5 billion was spent for hospital care in the United States, and in addition $2.5 billion was spent for construction and modernization of health care facilities. Approximately 51% of the $25 billion total came from the private sector, with philanthropy providing $2.3 billion of that 51%. Of particular significance is the fact that of the $2.3 billion from charity, 1.5 billion was for construction or modernization of facilities (or 60% of the $2.5 billion spent for construction). Hearings Before the Subcommittee on Medicare-Medicaid, Committee on Finance, 91st Cong., 2nd Sess., p. 422.

There are different rationale for granting tax benefits through exemption of income and deductibility of contributions to the donees of charities than for rendering property inalienable indefinitely according to the will of the deceased ancestor, under the law of charitable trusts. As stated above, reliance upon the authority of Scott is misplaced, even assuming it is accurate.[a] Rather than evaluating the competing claims of private persons over the use of property, tax benefits arise from legislative balancing of two competing public interests: one being that everyone pays his share of the costs and expenses of government (e.g. *Cleveland Osteopathic Hospital* v. *Zengerle*, 91 N.E. 2d 261, 263, Ohio, 1950; *Presbyterian Homes* v. *Division of Tax Appeals*, 261 A2d 143, N.J., 1970); the other being that "Government is compensated for the loss of revenue by its relief from financial burdens which otherwise have to be met by appropriations from public funds. . ." (Report 1860, Ways and Means Committee, 75th Cong., 3rd Sess., pp. 19-20, Jan. 1939). This "lessening the burdens of government" thesis is reflected in the current Treasury Regulations defining "charitable" for tax exempt purposes (Treasury Regulation 1.501(c)(3)-1(1)(d)(2)).

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[a] Even for the law of trusts, however, the law is not settled that a hospital, *per se*, is "charitable" without regard to free services to the poor. As stated in *Trust Co. of Georgia* v. *Williams*, 192 S.E. 2d 913, 914 (Supr. Cr., Ga., 1937). "A hospital, however, is not any more than a drugstore, a charitable institution *per se*; and, in order for a devise or other gift establishing a hospital to come within the classification of a charitable institution, the terms of the gift must themselves require that it be operated in whole or at least in substantial part for the gratuitous relief of its inmates."

It is not altogether clear how Scott came to his conclusion; many of the cases he cites in his long footnote actually spell out the requirement that the poor as well as the rich be treated in charitable hospitals. E.g., *Hart* v. *Taylor*, 301 Ill. 344, 133 N.E. 857, 858 (1922); *O'Brian* v. *Physicians' Hospital Ass'n*, 96 Ohio St. 1, 116 N.E. 975, 977 (1917). They rather support the proposition that health is a purpose which may be charitable, provided that actual charity is bestowed. This is fully in keeping with the pre-1969 posi-

However, whether an institution should qualify for tax benefits as lessening the burdens of government requires an evaluation of its operations in the realities of

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tion of the IRS. As stated in *Sonora Community Hospital*, 46 TC 519, 525-6 (1966), "The mere fact that petitioner maintained a hospital does not in and of itself justify the conclusion that it was operated exclusively for charitable purposes. While the diagnosis and cure of diseases are indeed purposes that may furnish the foundation for characterizing an activity as 'charitable' something more is required. See Rev. Ruling 56-185, 1956-1 C.B. 202."

The concept of charitable trusts emerges from the Statutes of Elizabeth I, and the relief of "aged impotent and poor people" set forth therein. This provision was part of the Elizabethean poor laws, and implicit throughout was the concept of assistance to the poor. As set forth in TenBroek, *California's Dual System of Family Law; Its Origin, Development, and Present Status*, 16 Stanford L. Rev. 257, 267 (1964),

> "Under the Tudors charitable foundations and the law of charitable trusts were developed in connection with the poor law. As the state assumed public responsibility for the poor, it built upon private charity and sought to encourage it. At best, such charity was an alternative to public expenditure; at least, it served as a method of reducing the cost. As the poor law system evolved, the Tudors sought to assure that charitable foundations devoted their resources without diversion or misapplication, that private and public charitable works were interrelated administratively, and the establishment of private charitable foundations occurred, especially in the area covered by the public responsibility. While we cannot ignore pressures arising from the political changes of the times and the developing *parens patriae* and police functions of the state, it is probably not too much to say that the modern law of charitable trusts evolved as an integral part of the poor law system and did so primarily because of the assumption of public responsibility by that system, with the resulting necessity of finding means of keeping down public expenditures."

The Statute was a product of the realization that laws against vagrancy and begging would not work if men were hungry, and the enlightenment when "the eminent statesmen of Elizabeth's reign courageously determined to act upon the principle that the relief of destitution must be undertaken as a public duty, and be provided for at the public charge, in order to ensure the due ascendancy of the law; and this principle was finally established by the passing of the 43rd Elizabeth." Nichols, *History of the English Poor Law*, 194 (1854).

its broad social context. For example, the accumulation of income for *future* charitable uses may not be sufficient for qualification. As stated by the Third Circuit in holding that the unreasonable accumulation of income deprived a charitable foundation of its tax exempt status:

> "It has no natural right to tax exemption, but rather a Congressional balm granted because losses in tax revenues were deemed compensated for by the value of charitable work. Absent a sufficient amount of charitable work commensurate with the total amount of Erie's available funds, exempt status must cease, or in fact, never come into existence." *Erie Endowment* v. *United States*, 316 F.2d 151, 153 (1963).

When one considers whether nonprofit hospitals which do not serve persons unable to pay for services should be nevertheless the beneficiaries of the Government's tax benefits policies, one must consider the over-all health delivery system in the United States, the crisis in that system, and the Government's policies and programs for dealing with that situation. In such a context the nonprofit, fee-charging hospital which does not serve the poor is not entitled to Government beneficence.

(A) *The Health Crisis in the United States and the Dual Hospital System Should be the Focus for Tax Policy in the Health Area.*

Accompanying this Statement is a collection of Documents, the common theme of which is the health crisis of the poor. Some of the Documents are Complaints filed in various Courts throughout the country and/or preliminary Decisions in some of the cases. Others are newspaper or magazine articles. They are illustrative of the fact that there is a health crisis in this country, and that the poor have been "squeezed" out of the system at the cost of their health and their lives.

The problems set forth in these Documents are manifold. In the first place they demonstrate that the poor are channeled into public hospitals in numbers beyond the capacity of the public hospitals with their limited budgets (determined by State or local governments) to cope, and that as a result serious shortages of staff, equipment, and facilities have precipitated charges of quality of care violations of statutory, regulatory, and constitutional obligations. (See, e.g., *Fisher* Complaint in Los Angeles (Document No. IIA), *Greater Washington Area Council of Senior Citizens* Complaint in the District of Columbia (Document No. IVA); Cf. *Boone* v. *Tate* Decision in Philadelphia (Document No. XIIA), and *Cook* v. *Ochsner* Complaint and newspaper clippings on Charity Hospital financial crisis in New Orleans (Documents Nos. VIIIA, VIIID).

In many of these places the private hospitals refuse to treat the poor (See *Cook* v. *Ochsner* Complaint in New Orleans; *Organized Migrant Workers* Complaint in Florida; *Perry* Complaint in the District of Columbia—Documents Nos. VIIIA, IVA, VA). Indeed, these fee-charging hospitals often discriminate against even the poor for whom the Government pays (See letters concerning minimal participation of New Orleans area fee-charging hospitals in Medicaid program, Document No. VIIB).

Throughout the country public hospitals have been faced with threatened or actual loss of accreditation (See clippings concerning the crises at public hospitals in the District of Columbia, Boston, St. Louis, Chicago—Documents Nos. IVB, VIA, IXA, XA), because of the quality of care problems. In other cities actual services and facilities have been curtailed (See *Boone* v. *Tate* Decision, clippings on New Jersey situation, *Cook* v. *Ochsner* Complaint and clippings on Charity Hospital crisis—Documents Nos. XIIA, XIA, VIIIA, XIIID).

In the private hospital system onerous deposit requirements are set as a barrier to the poor (See *Cook* v. *Ochsner* Complaint Document No. XIIIA), and the private hospitals have the notorious reputation for increasing the problems of the public hospitals by the practice of "dumping" their unwanted or poor patients upon the public hospitals. (See clippings reporting this practice in the District of Columbia and in Los Angeles, Documents Nos. IIB, IIIB). This practice has been recognized by persons within the inner sanctums of the hospital field. Thus, in the July 1970 issue of Hospitals, which is the official publication of the American Hospital Association, its feature editor states:

> "Whereas the 'mainstream' of health care during the 1950s and early 1960s was progressive and represented by research-oriented medical centers, public hospitals became the 'dumping grounds' for the medically indigent and had come to be identified with a dual standard of health care delivery. The passage of Medicare and Medicaid legislation in the mid-1960s was expected to unify the dual system. Unfortunately the private sector has not absorbed its proportionate share of the sick poor." (At 54)

It is a practice which violates the standards of the Joint Commission on Hospital Accreditation, which forbids transferring a patient without the permission of the recipient hospital, but nonetheless the practice persists.

In the April 1971 issue of Modern Hospital, it is reported that voluntary (i.e., private, nonprofit) hospitals have been limiting or eliminating the charity services in recent months (At pp. 40-41). In New Orleans, two of the private hospitals claim that they had free or below cost clinics which they closed in early 1970 (Answers to Interrogatories, *Cook* v. *Ochsner*, Civ. Act. No. 70-1969, E.D. La., 1970). Thus, while the public hospitals are

curtailing services because of budgetary limitations, so too are the private hospitals. At the same time States are claiming fiscal crisis in the Medicaid programs, most especially our wealthiest States of New York and California (See, *C.M.A.* v. *Brian*, Civ. Nos. 208390-209168, Superior Ct., Sacramento County, 1971; *Bass* v. *Rockefeller*, 71 Civ. 2088, SDNY, 1971). These documents describe a dual health system, the inadequate public one for the poor, the private one which is the beneficiary of all the major breakthroughs of modern medical science for the paying patients. This dual system has been characterized as "indefensible as a concept and unacceptable as a practice" (See, e.g., report of testimony before the Illinois State Senate investigating the plight of Cook County Hospital, Hospitals, May 1, 1970, p. 107). It is the practice which Medicare and Medicaid was suppose to eliminate. Indeed, specifically written into those Statutes is the "free choice" of providers requirement (See 42 U.S.C. 1395a, 1396a(a)(23)). During the hearings on Medicare and Medicaid in 1965, the California Medical Association expressed the sentiment that

> "it is important that the patient stay in the mainstream of medical care in his community. He should be subject to no discrimination or segregation from other citizens who are able to provide for their own care. He should be able to use the same facilities . . ." See Hearings before the Committee on Finance, U.S. Senate, 89th Cong., 1st Sess. on H.R. 6675, p. 656.

This dual health system has had a detrimental effect upon the health of the poor, and although a majority of the poor are not black, it has had a statistically measureable greater impact on the poor blacks. Although we have included only excerpts from the Devise Study (Document No. VIB), we commend the entire booklet for its documentation of the relationship between poverty and

race and poor health status. As noted in the Devise booklet, chapter 1, one of the most sensitive indices of health conditions in the community is its infant mortality rate, expressed as death of children under one year of age per 1,000 live births. In Chicago the non-white poverty community was measured as having an infant mortality rate of 45.5 per 1,000 live births compared to the white non-poverty community with 22.2 per 1,000 live births (See Devise, *Slum Medicine: Chicago's Apartheid Health System*, Jan. 1, 1969, U. of Chicago). Similarly, in the United States as a whole in 1967, infant mortality for whites was 19.7 per 1,000 live births and for nonwhites 35.9 (Statistical Abstract of the United States, 1969). In 1968, with an overall figure of 21.7 deaths per 1,000 live births, the United States ranked thirteenth among selected industrialized countries in infant mortality, following behind: Norway, Sweden, the Netherlands, Finland, Japan, Denmark, Switzerland, Australia, United Kingdom, New Zealand, East Germany, and France, (Population and Vital Statistics Report, Series A, Volume XXII, No. 1, January 1, 1970, United Nations).

This is the context in which tax benefits in the health area must be considered. It is the context to which the Senate Finance Committee deferred consideration of the issue, when it deleted the amendments giving hospitals as a class 170 and 501(c)(3) status apart from "charitable" in October 1969, a deletion which was accepted by the House in Conference.

(B) *Granting Hospitals Which Deny Admission to the Poor the Status of "charities" for Purposes of Section 170 of the Internal Revenue Code Defeats Both Tax and Health Policies.*

As stated above the decision to grant tax benefits to charities is the result of a legislative finding that the

benefits conferred (through a lessening of the burdens on the expenditures of government which would otherwise occur) outweighs the policy that everyone pays his share of the costs of government. The brief summary of the health crisis in the United States set forth above and in the attached documents demonstrates that when private hospitals take only patients who pay for the services rendered to them, and cast the entire burden of the poor upon the public hospitals, the burden on government increases. As cogently stated by the Illinois Court in denying tax exempt status to an old people's home which reserved the right to discharge a resident who became sick, unmanageable, or depleted his assets, and then to cast him upon the State for care,

> ". . . the State would be bereft of any asset or estate from which it might seek reimbursement for its outlay after the person's demise. We can only infer that plaintiff's use of its property in this respect could tend to increase, rather than lessen, the State's burden." *Methodist Old People's Home* v. *Korzen*, 233 N.E. 2d 537, 543, 39 Ill. 2d 149 (1968).

So too has the Louisiana Court, noting that the institution did not admit charity patients and scheduled charges even for welfare patients, stated,

> "there is no basis for the contention that plaintiff's operation in any degree whatsoever served to relieve the State or its governmental subdivision of the burden of caring for the sick and the indigent." *Ruston Hospital* v. *Riser*, 191 So 2d 664 (1966).

Likewise the New Jersey Courts have recognized that the failure to care for the aged poor by private homes casts a financial burden on the State. See *Presbyterian Homes* v. *Division of Tax Appeals*, 261 A2d 143, 55 NJ 275 (1970); *Catholic Charities* v. *City of Pleasantville*, 263 A2d 803, 109 N.J. Super, 475 (1970).

Further, Government health policy is directed toward the elimination of the dual system of health care. It was the objective of the Medicare and Medicaid systems. To the extent that the poor are still funnelled into the public hospitals, it is a reflection upon the private hospital system (See letters concerning non-participation of private hospitals in Medicaid in New Orleans, Document No. VIIIB) which has "chosen" not to participate. But should private hospitals which refuse to participate in extending health services to the entire community which must include the poor, and which cast the burden of the poor entirely upon the public sector, be granted subsidization of public revenues through tax benefits? That is the basic policy question. We believe that it belongs most appropriately with Congress. However, in view of the removal of the sanction of loss of tax exempt status, which has encouraged hospitals to close down charity services, we suggest that the Regulations under section 170 be amended to restore the prior, long-standing, and legally approved policy that only those nonprofit hospitals which do not turn the poor away may be the beneficiaries of tax-deductible contributions.

INDEX OF DOCUMENTS IN SUPPORT OF STATEMENT

[Documents Omitted]

Document No.:

I. Arizona

A. Affidavit of Carolyn Block

II. California—Quality of Care to Poor; an Issue in Public Hospitals in Los Angeles County.

A. *Dr. Charles Fisher, et al.* v. *County of Los Angeles, et al.*, Civil Action No. 96821 in the Superior Court of the State of California for the County of Los Angeles.

B. Newspaper clippings concerning the *Fisher* lawsuit.

III. Colorado—Poor Charge that Public Hospital Refuses to Serve Them Without Cost.

A. *Rafaelo Euresti, et al.* v. *Richard Stenner, et al.*, Civil Action No. C-2462 in the United States District Court for the District of Colorado.

IV. District of Columbia

A. *Greater Washington, D.C. Area Council of Senior Citizens, et al.* v. *District of Columbia General Hospital, et al.*, Civil Action No. 275-71 in the United States District Court for the District of Columbia.—Quality of Care Problem in D.C.

B. Newspaper clippings of problems at D.C. General.

C. *Elizabeth Perry, et al.* v. *The Greater Southeast Community Hospital Foundation, Inc., et al.*, Civil Action No. ——— in the United States District Court for the District of Columbia.—Poor Charge That Private Hospital Refuses to Treat Persons Unable to Pay.

INDEX OF DOCUMENTS (Continued)

V. Florida—Poor Charge Private Hospital Refuses to Treat Persons Unable to Pay.

A. *Organized Migrants in Community Action, Inc., et al.* v. *James Archer Smith Hospital, et al.,* Civil Action No. 70-1794-Civ. JLK in the United States District Court Southern District of Florida.

1. Complaint
2. Decision on Standing and Class

VI. Illinois—Quality of Care for the Poor an Issue in Chicago

A. Newspaper clippings concerning crisis at Cook County Hospital.

B. Excerpts from *Slum Medicine: Chicago's Apartheid Health System,* De Vise.

VII. Kentucky

A. Newspaper clippings on charges by poor that private hospital refuses to treat persons unable to pay—emergency results in death.

VIII. Louisiana—Poor Charge Private Hospitals Refuse to Treat Persons Unable to Pay and Persons on Medicaid, and Inequality of Care and Lack of Available Services Exist at Public Hospital.

A. *Rosezella Cook, et al.* v. *Ochsner Foundation Hospital, et al.,* Civil Action No. 70-1969 in the United States District Court, Eastern District of Louisiana, New Orleans Division. Complaint.

B. Letters concerning failure of private hospitals to Participate in Medicaid.

C. Court's Memorandum of Reasons in *Cook,* 319 F. Supp. 603, on Standing of the Poor.

INDEX OF DOCUMENTS (Continued)

D. Newspaper clippings concerning crisis at Charity Hospital.

IX. Massachusetts—Quality of Care—An Issue at Public Hospital in Boston.

A. Newspaper clippings concerning Boston City Hospital.

X. Missouri—Quality of Care, an Issue at St. Louis General Hospital.

A. Newspaper clippings.

XI. New Jersey

A. Clippings concerning the closure at public hospital of services to the poor.

XII. Pennsylvania—Lack of Money Results in Closing Services to the Poor at Public Hospital—Quality of Care Issue.

A. *George and Patricia Boone, et al.* v. *James H. J. Tate,* Civil Action No. 713 in the Court of Common Pleas of Philadelphia County Trial Division—Civil Section. Final Decree.

XIII. Miscellaneous Articles Regarding Health Crisis, Medicaid Cut-backs as States Face Financial Crises, etc.

EXHIBIT 3

AFFIDAVIT

District of Columbia, ss:

I, Anthony Z. Roisman, being duly sworn, deposes and state as follows:

1. I am counsel for plaintiffs in the action styled *E.K.W.R.O. et al.*, vs. *Schultz et al.*, Civ. Act. No. 1378-71. For several months prior to the commencement of the action on July 12, 1971, I consulted with legal service attorneys whose clients were poor people denied access into non-profit hospitals across the country because of their inability to pay for hospital services. These attorneys were particularly concerned with a recently issued ruling of the Internal Revenue Service (Rev. Rul. 69-545) that reversed the prior ruling (Rev. Rul, 56-185) that required non-profit hospitals not to deny service to the poor in order to retain "charitable" tax exempt status under section 501(c)(3) of the Internal Revenue Code.

2. On May 22, 1971 there appeared in the Federal Register a Notice of Hearing on Proposed Regulations concerning the "charitable" contributions provisions of the Internal Revenue Code (36 Fed. Reg. No. 100). Viewing this proceeding as an opportunity to present to the internal Revenue Service and the Department of the Treasury its views of the poor people with respect to the issue of "charitable" service of hospitals, in particular to contend that revenue ruling 69-545 was based on a lack of understanding of health crises poor people faced, and desiring a more favorable ruling in the "contributions" area, we filed a Statement (copy of which is attached to the Motion for Summary Judgment as Exhibit 2) on behalf of the National Legal Program on

Health Problems of the Poor and a number of its organizational and individual clients.

3. The hearing was conducted on June 28, 1971, and I appeared for the organizations, individuals, and programs identified on Exhibit 2. The chairman of the three member panel informed me that as I was present I could testify, but to be brief, as the matters which were the subject of my testimony were irrelevant to the purposes of the hearing, and that I was addressing myself to the wrong forum. I spoke approximately for ten minutes. The panel was not responsive to the issues I raised.

4. I reported to Marilyn Rose and Laurens Silver of the National Legal Program on Health Problems of the Poor what occurred at the meeting. Subsequently I was told by Ms. Rose and Mr. Silver that they had discussed the matter with the various local legal service attorneys and their clients, and the decision was made that a lawsuit challenging the action of Defendants was the only alternative open.

/s/ Anthony Z. Roisman
ANTHONY Z. ROISMAN

Sworn to before me this 6th day of April, 1973.

/s/ Phyllis L. Quander
Notary Public
My commission expires January 31, 1978.

(Official Seal)

EXHIBIT 4

AFFIDAVIT

State of Kentucky

County of Floyd

I, Eula Hall, being duly sworn, depose and state as follows:

1. The Eastern Kentucky Welfare Rights Organization, Inc., hereinafter E.K.W.R.O., was formed in September 1967 when a group of residents of Floyd County, Kentucky, distressed at their poverty, decided that poor people had a right to the decision-making process in the United States, particularly with regard to their health, education, and welfare.

2. I have been a member of E.K.W.R.O. from its founding, and am presently the Chairman of the Health Committee. The Health Committee was founded two years ago when problems developed with the O.E.O. funded comprehensive health program. The comprehensive health program had no doctors, no drugs, and served merely as an outpost or way station to funnel people to local medical facilities where patients were herded into and waited for hours in crowded clinics to be seen.

3. E.K.W.R.O. has grown to a membership of approximately 500 people, principally from Floyd County, but also from Pike, Knott, and Manifee Counties, Kentucky. The members must be low income, using the O.E.O. guidelines as the criteria for low income. Most of the men have been miners, who have either been injured or have contracted black lung disease. Many of our members actually have no income except food stamps, having been denied welfare and black lung benefits.

4. One of the principal projects of E.K.W.R.O. has been a proposal for the Mud Creek Health Program.

Mud Creek is the home for about ⅓ the population of Floyd County, some 10,000 people. Most of the men of Mud Creek are or have been employed as coal miners. The older men are usually disabled and suffer from chronic lung disease and related health problems such as enlarged heart. Because many of the strongest and healthiest people have left the area to go to industrial centers for work, those left behind in the mountains are often those who are most in need of health care: the aged, the injured, mothers and their children, and those men who face the day-to-day hazards of working in the coal mines. Most poor people who have grown up on Mud Creek also suffer from health problems related to poor housing and sanitation, and the lack of money to buy the necessary foods and medicines.

5. Health resources in Mud Creek are scarce, and transportation over Mountain roads is virtually nonexistent. Thus people go to seek health care when they feel it is an emergency, only to wait in crowded hospital clinics and emergency rooms all day long and into the night. Added to that is the fact that if people do not have money, they do not get treated.

6. As the Chairman of the Health Committee I have taken poor people to hospitals in the area and have waited with them for hours to be seen, only to be turned away because they had no money.

7. I have read the affidavits given by Artie and Clarence Tackett, Tora Mae Collins, and Lard Collins, and personally know that their circumstances in seeking health care unsuccessfully from hospitals in the area from which E.K.W.R.O. draws its members are typical.

8. In June 1971 I and other representatives of E.K.W.R.O. met with the Administrator of the Pikesville Methodist Hospital to discuss hospital admission policy. He informed us that the Pikesville Methodist

Hospital treats Floyd County people just like they treat Pike County people—if they don't have the money, they don't get in.

/s/ Eula Hall

Subscribed and sworn to before me this 31st day of January, 1973

/s/ [Illegible]
Notary Public

My Commission Expires: January 4, 1977

EXHIBIT 5

AFFIDAVIT

State of Kentucky

County of Floyd

I, Artie Tackett, and I Clarence Tackett, being duly sworn, depose and state as follows:

1. We have fourteen children, seven of whom are still minors and live at home.

2. Clarence Tackett worked in the mines for twenty-one years, developed problems with breathing, and became unable to work any longer in the mines. He has not been determined eligible for social security benefits under the Black Lung Benefits Act, and the family has been subsisting only on food stamps. In 1971 he participated in the Mainstream Program, but there were no jobs.

3. In January 1971 Clarence Tackett took Artie Tackett to the hospital at Prestonburg (Highland General Hospital). She had had two previous heart attacks and he thought she might be having another heart attack. The nurse on duty asked for $50. When Clarence Tackett said that he did not have the $50, the nurse tore up the admission's application. He told the nurse that his wife had had two previous heart attacks, but the nurse refused to call a doctor. Clarence Tackett had to take Artie Tackett home without any treatment.

4. This is the typical action of all the hospitals in the area. In 1968 when Artie Tackett had a heart attack Clarence Tackett had to give the Beaver Valley Hospital his car (worth about $500) because he did not have even $50 for admission. About four years ago the Prestonburg Hospital would not admit their daughter Patty.

then 9, who was suffocating from worms, because they did not have the $50.

5. Clarence Tackett himself has black out spells, has shown positive on the tuberculosis skin test, and probably has cirrhosis, in addition to his probable black lung disease.

/s/ Clarence Tackett
Artie Tackett

Subscribed and sworn to before me this 31st day of January, 1973.

/s/ [Illegible]
Notary Public

My Commission Expires: January 11, 1977

EXHIBIT 6

AFFIDAVIT

State of Kentucky

County of Floyd

I, Tora Mae Collins, being duly sworn, depose and state as follows:

1. In June 1971 I went to the Prestonburg Hospital (Highland General). I was pregnant and had severe labor pains. I am a beneficiary of Medicaid and had a Medicaid card. However, the people on duty at the Prestonburg Hospital told me that my Medicaid card was not enough, that I needed $90 in addition. Two to three weeks earlier I had also been told by the people at the Prestonburg Hospital that my Medicaid card was not enough, that I needed $90. On both occasions they would not treat me, nor would anyone examine me although I was in severe pain.

2. My husband and I had absolutely no income and no resources, and had no way to pay for any medical care except for the Medicaid card. Unlike the Prestonburg Hospital the Pikesville said that the Medicaid card would pay for my care and I went there when I did deliver. I went to the Prestonburg Hospital earlier because it was a great deal closer and I did not think that I could make it to Pikesville. We do not have any transportation.

/s/ Tora Mae Collins

Subscribed and sworn to before me this 31st day of January, 1973.

/s/ [Illegible]
Notary Public

My Commission Expires: January 4, 1977

EXHIBIT 7

AFFID. VIT

State of Kentucky
County of Floyd

I, Lards Collins, being duly sworn, depose and state as follows:

1. In August 1972 Dr. Hodge sent me to Pikesville Methodist Hospital. He said that I had gallstones and needed an operation or I might bleed to death. He gave me a paper which I took to the hospital and gave to one of the nurses who sent me to the main office. At the main office I told them that I had only a $80 a month income, and nothing left after I paid rent and the gas bill and I had no health insurance.

2. I was told by the woman in the main office that they would not take me. I asked what would happen if I died. They said that Dr. Hodge was not running the place.

3. I worked for the railroad and was a miner for twenty years. But I am now disabled and receive the $80 a month as social security disability benefits. I have an application in for black lung benefits, which was rejected, but I have refiled and have heard nothing. I have no other income.

4. Dr. Hodge told me that my heart is weak and cannot stand the problems from my gallstones.

/s/ Lards Collins

Subscribed and sworn to before me this 31st day of January, 1973.

/s/ [Illegible]
Notary Public

My Commission Expires: January 4, 1977

EXHIBIT 8

STATE OF ARIZONA)
) ss.
COUNTY OF PIMA)

I, CAROLYN BLOCK, being first duly sworn, depose and say:

That my husband, HENRY BLOCK, and I live at 729 E. Mabel Street, Tucson, Arizona. We have three children, their ages are six years, 4 years and four months. The burden of expenses in keeping our children properly clothed and fed is large. In addition we must pay $90.00 per month for rent.

My husband, Henry Block, earns approximately $200.00 per month by working at property maintenance, gardening and general repair.

Our low-income makes it impossible for us to pay for hospital care. We are in an especially bad condition with respect to medical care because Arizona has no Medicaid Program to help us out.

At the present time we owe $88.00 in medical bills to Tucson Medical Center. The bills were incurred as a result of emergency medical care for our youngest child and emergency medical care for me. At the time of our medical treatment at Tucson Medical Center, the hospital was aware of our indigency status. Yet they have now turned the full bill over to a collection agency and we are being threatened with a suit.

Tucson Medical Center refuses to let poor people in the hospital when they can not pay the full bill, so we are not able to and will not use this hospital again.

/s/ Carolyn Block
CAROLYN BLOCK

SUBSCRIBED AND SWORN TO before me this 24th day of May, 1971.

/s/ Rose M. Lowe
Notary Public

My Commission Expires. June 6, 1972

EXHIBIT 9

AFFIDAVIT

STATE OF WEST VIRGINIA

COUNTY OF BOONE, To-wit:

Howard Linville, of the Town of Fosterville, County of Boone, State of West Virginia, being duly sworn on his oath deposes and says:

1. That he is Treasurer of the Association of Disabled Miners and Widows, Inc.;

2. That the Association of Disabled Miners and Widows, Inc. is a non-profit corporation duly organized under the laws of West Virginia and having a membership of approximately 4,000 disabled miners and widows who reside in many states throughout the nation, including the Appalachian states of West Virginia, Kentucky, Pennsylvania, Ohio and Tennessee;

3. That the Association of Disabled Miners and Widows, Inc. is organized for the purpose of liberalizing pension benefits and enforcing proper rules and regulations under the United Mine Workers of America Welfare and Retirement Fund, as well as concerning itself as an organization with the related problems incident to member disabilities and infirmities;

4. That the member disabled miners and their widows are poor persons who are for the most part disabled miners or their widows with little or no outside income;

5. That the member disabled miners and their widows have no United Mine Workers of America hospital

cards, by which other members of UMW of A are afforded medical and hospital care for their health problems;

6. That the member disabled miners are persons who have spent many years in the most dangerous industry occupation in the United States, namely, the mining of coal, and that they are afflicted by a high incidence of traumatic injuries and disabilities as well as Pneumoconiosis of the lung (Black Lung) and that many of the members, including widows are elderly and, therefore, susceptible to the common and regular ailments of old age;

7. That low income status of the member disabled miners and their widows render them unable to pay hospital fees for the diagnosis and treatment of their various ailments;

8. That in individual cases member disabled miners and their widows have been unable to receive proper diagnosis and treatment, or even been turned away, from various private, non-profit hospitals throughout the region.

/s/ Howard Linville

Subscribed and sworn to before me this 27 day of Feb., 1972.

/s/ [Illegible]
County Clerk
Boone County,
West Virginia

My Commission expires:
12-31-72

EXHIBIT 10

AFFIDAVIT

I, Rosezella Cook, having been duly sworn do hereby depose and say:

1. I live at 2652 Alvar Street, New Orleans, Louisiana, where I have lived for the past seven years with my five children. This an apartment in the Florida Project of the Housing Authority of New Orleans.

2. My total family income for the five of us is $72.00, plus $160.00 per month for a housekeeper paid by the Welfare Department because of my health. We are so poor that I am unable to get the foods that doctors tell me to eat.

3. Four of my children are in school, and the fifth, an 18 year old boy has been looking, without success, for several months for a job. Unemployment is so high among young black men that he is becoming very discouraged.

4. My health has been very bad for several years now. From the Spring of 1970 I have tried to get treated for my high blood pressure, by the private hospitals in New Orleans, without success. Last year I was in public hospitals three times for several weeks at a time. The first two times I was in Charity Hospital. The third time I was hospitalized was in November 1972. This occurred when one day I had severe chest pains, and went to the Neighborhood health clinic. The doctor said I had to go right into the hospital. He thought I was having a mild heart attack. I told him I did not want to go to Charity Hospital, the local public hospital, because in my opinion, they were so overcrowded they are unable to give good treatment sometimes. The nurse called two hospitals to get me admitted but was unsuccessful. The

doctor then made special arrangements and got me admitted at the Public Health Hospital, where I stayed 27 days. I got good service there. I hope I and my children can get service there or at a private hospital in the future.

/s/ Rosezella Cook
ROSEZELLA COOK

Sworn to and subscribed before
me this 5 day of April, 1973

/s/ Elizabeth H. Z. Halstead
Notary Public

EXHIBIT 11

AFFIDAVIT

I, Monica Hunter, having been duly sworn do hereby depose and say:

1. I now reside at 3647 St. Ferdinand Street in New Orleans, Louisiana. I live there with my four children.

2. Our total family income to support the whole family is $90.00 a week from my job with New Orleans school system, as a tutor, plus $196.00 per month for Social Security survival benefits.

3. Two of my children, Craig, 15 and Dent, 11 are very sick with sickle cell anemia and require extensive medical care. Craig has had three sickle cell crises in the last years and Dent one. These can be very severe. For example, during Craig's last crisis, he was rushed to the hospital as an emergency patient. He was given I.V. transfusions, drugs, and oxygen and kept in the hospital for 12 hours. We took him to Charity Hospital because we are too poor for the voluntary hospitals. Charity, the state public hospital, treats us, but they are so overcrowded that we can never be sure we will get the treatment needed. Also, Charity is far away from us. There are two or three voluntary, tax-exempt hospitals that are closer and it would be important to use them when one of my children has a sickle cell crisis. However, we don't have the money needed at these hospitals.

4. In addition to the above, my family is forced to use Charity Hospital at a minimum of ten times a year for various things. I wish we could use a closer hospital, but we are too poor.

/s/ Mrs. Monica Hunter
MONICA HUNTER

Sworn to and subscribed before
me this 4 day of April, 1973

/s/ Elizabeth H. Z. Halstead
Notary Public

EXHIBIT 13

AFFIDAVIT OF RACHEL MILLER

I am the duly-elected President of the California Welfare Rights Organization (CWRO) and am authorized to make the following statements.

CWRO is an unincorporated, voluntary association of low-income persons in California. The organization is the state-wide affiliate of the National Welfare Rights Organization. Presently, CWRO has an active membership of approximately 3,000.

CWRO's members include recipients of every form of public welfare—Aid to Families with Dependent Children, Aid to the Needy Disabled, Aid to the Blind, Old Age Security, and General Assistance, as well as recipients of Food Stamps and Medi-Cal (Medicaid) benefits. Many of our members also receive Social Security, Medicare, Unemployment Insurance, and other social insurance benefits.

Not all of our members are recipients of public assistance or social insurance benefits. Many are simply poor persons unable adequately to provide for themselves and their families, yet ineligible for welfare because of restrictive eligibility conditions. Some of our members are former recipients who are still impoverished but have left the welfare rolls because of changes in governing laws, or the members' economic or other circumstances.

CWRO represents and seeks to protect the interests of its membership. CWRO actively asserts the rights of the poor to cash assistance, health and medical care, and all other forms of public aid. The organization attempts to change restrictive conditions and practices which close off the poor from the enjoyment of their statutory and constitutional rights to these benefits.

In representing the interests of its impoverished members, CWRO initiates litigation in the state and federal courts to obtain for the poor benefits conferred by law. CWRO's standing to litigate such issues is expressly recognized by the California Supreme Court in *CWRO* v. *Carleson*, 4 Cal.3d 445 (1971) and *County of Alameda* v. *Carleson*, 5 Cal.3d 730 (1971). In *CWRO* v. *Richardson*, 348 F.Supp. 491 (1972), the organization litigated its members' rights to health care benefits under federal law.

/s/ Rachel Miller
RACHEL MILLER

Subscribed and sworn to before me
this 31 day of March, 1973.

/s/ C. Robert Trentham
Notary Public

[SEAL]

OFFICIAL SEAL
C. ROBERT TRENTHAM
Notary Public—California
Los Angeles County
My Commission Expires Sept. 3, 1973

EXHIBIT 14

AFFIDAVIT

I, Marilyn G. Rose, being duly sworn, depose and state as follows:

1. I am Counsel of Record for Plaintiffs in the case of *Cook et al.* vs. *Ochsner Foundation Hospital et al.*, Civ. Act. No. 70-1969, E.D. La.

2. The attached, as described below, are true copies of Affidavits submitted by Plaintiffs in said case;

(a) Affidavits submitted in support of Motion for Preliminary Injunction (never heard) and resubmitted in support of Motion for Summary Judgment against Elliot Richardson as Secretary of Health, Education, and Welfare:

Exhibit A—Rosezella Cook
Exhibit B—Sallie Lee
Exhibit C—Monica Hunter
Exhibit D—Ora Pearl Price
Exhibit E—Merita Delores Moore
Exhibit F—Mary Jones
Exhibit G—Shirley Lampton
Exhibit H—Wilhemenia Brown
Exhibit I—Dr. Rob Robertson
Exhibit J—Jeffrey B. Schwartz and Clifford Breaux
Exhibit K—Edward Booker

(b) Affidavits submitted in support of Motion for Summary Judgment against Elliott Richardson as Secretary of Health, Education, and Welfare:

Dr. Albert J. Lauro
Dr. Rod Yeager
Dr. Charles C. Mary, Jr.
Raymond Downs, with attachments

3. In Appendix 6B of the Pre-trial Order Ochsner Foundation Hospital stipulated as fact to the following:

> "The records of Clifford Breaux show that he was an inpatient at Ochsner Foundation Hospital on two occasions, the first being in July, 1968 and the second occasion being in June, 1970. At the time of the first admission, a memorandum entitled "From the Desk of Clifford C. Losberg, Jr." states, "Earl—re Clifford Breaux. Will get $200 prior to admission & can come up with about $500 more in cash. Owns clothing store & oy (sic) clinic bills currently. Dr. Hatch says he will keep in 5 to 7 days, no more. L." He stayed in the Hospital 12 days. The statement for this hospital admission dated August 29, 1968 states that $482.85 was due, and further states "Sorry, but we cannot accept less than $100.00 a month. It is unusual for the Hospital to permit terms at all." At this time he had paid $50 in addition to the $200 at admission. Thereafter, Mr. Breaux paid this bill off, in monthly installments which ranged from $50 to $100. Mr. Breaux continued to be a patient at the chest clinic, being seen there on seven occasions between August 1968 and June 1970. On May 1, 1970 (the seventh occasion), the chest clinic record states: "This patient needs to be hospitalized and he can't afford OFH. Will write a letter to Charity Hospital and hope they will take him. /s/ Hatch, M.D.X." The next record indicates that he was admitted June 11, 1970 and died on the morning of June 22, 1970. The diagnosis on autopsy shows the following conditions:
>
> 1. extreme obesity
> 2. bleeding duodenal ulcer, w/massive hemorrhage in GI tract
> 3. multiple pulmonary thromboemboli bilaterally

> 4. congestive heart failure, w/cardiomegaly
> 5. mural thrombi, right auricle & ventricle
> 6. anascarca (edema all over)
> 7. congestion of lungs and liver
> 8. adrenal cortical nodular hyperplasis
> 9. thrombosis of the periprotatic venis
> 10. adenomata of the colonic mucosa
> 11. prostatic calculi
> 12. mild diabetes mellitus, "clinically."

subparagraph c(34)

/s/ Marilyn G. Rose
MARILYN G. ROSE
Washington Counsel
Health Law Program
733 - 15th St., N.W.
Room 236
Washington, D. C. 20005
(202) 783-1666

Sworn to and subscribed before me this 10th day of April, 1973.

/s/ Justin V. O'Conor
JUSTIN V. O'CONOR
Notary Public
My Commission Expires May 11, 1974

EXHIBIT A

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before Me, a Notary, appeared the undersigned, Rosezella Cook, who declared under oath that:

1. I am a female, 33 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is at 2652 Alvar Street in the Florida Housing Project of the Housing Authority of New Orleans. I live there with my six children for whom I am sole support.

3. My family income is derived from a monthly welfare check totaling $73 per month. My family does not receive any other source of income. Welfare also pays $160 for a full time house keeper since I am so ill I can do no house work and need full time care.

4. I am suffering from a heart condition, high blood pressure and extreme nervousness.

5. I am eligible to receive treatment for my condition at Charity Hospital. For several years, I have been going to Charity Hospital's out patient medical clinic every two weeks to receive medicine for my condition. These drugs have not helped me, and in fact, my condition has worsened considerably. I was admitted into Charity Hospital on April 2, 1970, because my blood pressure had risen to 26/146. I was released from Charity Hospital on April 17, 1970, but the treatment I received did not help me.

6. In need of treatment, and knowing that the drugs I have been receiving at Charity Hospital have not helped one, I decided to go to Methodist Hospital, 5620 Read Road, which is reasonably close to my home, to see if they would treat me.

7. On June 28, 1970, I went to Methodist Hospital and asked to be seen. I told the admit clerk that I was suffering from very high blood pressure and a chronic heart ailment. I also told her that I was a welfare recipient. The clerk told me that I would have to pay $10 just to be seen in the emergency room and that a total deposit of $35 was required, since the total bill with tests would amount to at least $35. The admit clerk also said that I cannot be accepted even if I borrow the required deposit, since it would take too much out of my welfare check. I could not be seen at Methodist Hospital because of my poverty.

8. I am in desperate need of treatment for my condition. I have no money to receive the necessary medical treatment I need. The treatment I have received at Charity Hospital has not helped me. I have nowhere to turn.

/s/ Rosezella Cook
ROSEZELLA COOK

Sworn to and Subscribed before me this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public
Parish of Orleans, State of La.
My Commission is issued for life

EXHIBIT B

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before Me, a Notary, appeared the undersigned, Sallie Lee, who declared under oath that:

1. I am a female, 48 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is at 2814 Alvar Street, Apartment C, in the Desire Housing Project of the Housing Authority of New Orleans. I live there with my six children for whom I am sole support.

3. Our total income for the seven of us is $244 monthly, of which $32 per week is derived from part time employment as a health worker in a Total Community Action training program and $116 per month is derived from welfare payments. My family does not have any other sources of income. Because of our extreme poverty, my family also is eligible for and receives food stamps, federal assistance through public housing for shelter, and federal assistance for medical services through the Medicaid Program.

4. For many years, I have been suffering from a severe case of arthritis and from high blood pressure.

5. I am eligible for and have received treatment for my condition at Charity Hospital. The treatment I have received there has not helped me and my condition has worsened most recently.

6. Being in desperate need of treatment and having received no results at Charity Hospital, I decided to make

an attempt to be seen at the Ochsner Clinic, because I was told that the doctors there are very good and would be able to help me.

7. On June 29, 1970, I went to Ochsner Clinic where a nurse opened a file in my name. It was noted that I was a welfare recipient. I was then sent to the emergency room of Ochsner Hospital. I spoke to a nurse in the emergency room and told her that I was very ill and needed treatment. The nurse told me that a $35 deposit would be required before I could be seen, but since I was a welfare recipient, I could not be seen even if I borrowed money or sacrificed some of my welfare money to pay the required deposit. I told the nurse I could pay the deposit, but she again said that I couldn't be treated. The nurse then sent me back to the Clinic, but she said they probably wouldn't see me there either since I was a welfare recipient. I returned to the Ochsner Clinic where a nurse asked me what my income was. I told her that I was a welfare recipient, but she said welfare is not income and that I was too poor to qualify for treatment at Ochsner Clinic. I asked the nurse if she could recommend me to someone else, but she said the only hospital I can advise you to go to is Charity Hospital.

8. I am a very sick woman. The treatment I have received at Charity Hospital has been of no help to me. I need immediate and proper treatment for my condition.

/s/ Miss Sallie Lee
SALLIE LEE

Sworn to and subscribed before me this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT C

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Monica Hunter, having been duly sworn, do hereby depose and say:

1. I am an adult, black, female and a citizen of Louisiana and the United States.

2. I reside at 416 North Villere Street in the Iberville Housing Project of the Housing Authority of New Orleans. I live there with my four children for whom I am the sole support. My husband died several years ago.

3. Our income for the five of us is $147 primarily from my husband's social security benefits. Because we are so desperately poor, we also are eligible for and do receive food stamps, federal assistance through public housing for shelter, and federal assistance for medical services through the Medicaid Program.

4. Over the past month or more I have been having pains in my lower abdomen and headaches. About a month ago, I went to Charity Hospital and was told I had a kidney infection and given certain medicine. Although I took this medicine as directed, I have felt no better. In fact, I have been getting progressively worse.

5. On Saturday night, June 20, 1970, I was in severe pain. I could not sleep all night. Because of this, I went to Charity Hospital first thing Sunday morning and was there at 8 o'clock. The doctor there told me that I did not have a kidney infection that I had something else and he gave me some other medicine. I have taken that medicine this week without any relief.

6. The pains in my lower abdomen are very severe, although, fortunately, they are not continuous and come and go. The pressure and pain in my head are getting worse, and I am really frightened that I have some serious illness. I believe that I need several elaborate and extensive medical tests to determine exactly what is the matter with me and full medical treatment, possibly hospitalization.

7. Because I know that Charity Hospital is so overcrowded and does not admit patients or give the full tests because they do not have adequate funding, I decided to try to get other medical care. On Friday, June 26, 1970, I went to Methodist Hospital, 5620 Read Road, hopefully to get medical treatment. I was told by the receptionist at the hospital that the hospital was a private one for private patients only. I was told that I must have a doctor. I was also told that they might call one of the doctors on the staff for me if I would pay $25 in advance or if I had a Bankamericard or a Master Charge card. I told the receptionist that this was ridiculous because I was a social security recipient. I told her that I was on Medicaid and that my hospital bills would be paid through that program. Still, they would not help me at Methodist Hospital.

8. I then went to the Hotel Dieu Hospital in an attempt to get medical treatment. I was told at this hospital that they only treated private patients since it was a private hospital. They would not even allow me to see a doctor. I must have a private doctor in order to get into the hospital. Further, I would have to pay for any medical treatment. My medicaid program would not be accepted. Of course, I cannot afford a private doctor and that is why I am seeking help at hospitals. Still, they would not help me.

9. Having been unable to get any medical treatment elsewhere, I guess I will have to go back to Charity al-

though I know they are not taking care of me. I wish there was some way I could get medical assistance. I am very worried about my health.

/s/ Mrs. Monica Hunter
MONICA HUNTER

Sworn to and subscribed before me this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT D

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before me, Notary, appeared the undersigned, Ora Pearl Price, who declared under oath that:

1. I am a female, 46 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is 3703 Benefit Street, Apartment C, New Orleans, Louisiana, where I live with my thirteen children and my disabled and unemployed husband.

3. My family's income is derived from a monthly welfare payment of $134.00 and monthly social security checks for my husband and my children totaling $262.00. My family does not have any other sources of income.

4. For the past several years I have been suffering from a stomach ailment which has caused severe nauseation, and I have also been suffering from obesity and high blood pressure.

5. I am eligible for Medicaid benefits. Since 1956 I have been going to Charity's out-patient clinic where I have had my blood pressure tested. In 1964 I was admitted into Charity Hospital for a hernia infection but was not operated on.

6. In March 1970, I went to Charity Hospital to again have my blood pressure tested. At that time, the residing physician told me not to come back to Charity Hospital until I lost thirty pounds.

7. During the past few weeks, I have become severely nauseated several times and my stomach pains have intensified. Afraid I wouldn't be seen at Charity Hospital because I hadn't lost thirty pounds, I decided to make an attempt to be examined and hopefully admitted into Touro Infirmary. I decided to go to Touro Infirmary since I was treated there in 1954.

8. On June 29, 1970 I went to Touro Infirmary in order to get treatment for my condition. I first went to the in-patient admitting desk. I went to the emergency room and there told the clerk I was ill and wished to be examined by a physician. I also told her that I was poor and unable to pay any fees. She told me that I would have to pay $35.00 for a physician to examine me and that I would have to pay in advance for all tests to be performed. Unable to pay the required fees, I left Touro Infirmary without receiving any treatment.

9. My sickness has worsened steadily in the past few weeks. I am in need of medical treatment but I am unable to pay for hospital or doctor fees. The treatment I received at Charity Hospital has not cured, or even helped my ailments.

/s/ Ora Pearl Price
ORA PEARL PRICE

Sworn to and subscribed before me this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT E

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before Me, a Notary, appeared the undersigned, Merita Delores Moore, who declared under oath that:

1. I am a female, 29 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is 5320 Florida Avenue, New Orleans, Louisiana, where I live with my three children, ages 12, 10, and 5. I am the sole support of these three minors.

3. My income is derived solely from welfare payment, such income amounting to $110 per month.

4. During the past few months, I have been suffering severe stomach pains and I also have been suffering from a chronic heart ailment.

5. Because I have no money whatsoever to pay a private physician, I have been going to Charity Hospital's outpatient clinic for the treatment of my condition. I last visited Charity Hospital in March, when at that time, after waiting an unreasonable period of time to be seen, I was given some pills for my stomach ailment and sent home.

6. Since March, and especially during the past few weeks, my condition has worsened considerably. The pains in my stomach have become unbearable.

7. On June 29, 1970, I decided to go to Flint-Goodridge Hospital to see if I could get treatment for my condition. I spoke to the clerk at the admitting desk who asked me if I had the recommendation of a private physician. Upon telling her that I didn't know a private physician, she recommended that I contact one of three specified doctors in the New Orleans Medical Association. I then asked the admit clerk if I would have to pay for hospital services provided by one of the above named physicians. I told her that I was unable to pay for any hospital treatment, including a deposit, since I was a welfare recipient with a meager income. The clerk then informed me that it was a hospital requirement that I pay a $250 deposit if I was to be admitted into the hospital as well as any other costs incurred while I was an in-patient at the hospital. She said the only exception to this deposit requirement, was if I could produce proof of hospitalization insurance. Having no hospital insurance and being unable to afford the required $250 deposit, I left Flint-Goodridge Hospital without being examined.

8. The drugs I received at Charity Hospital have not helped cure my stomach ailment. I have no money to receive the necessary medical treatment I need.

/s/ Merita Delores Moore
MERITA DELORES MOORE

Sworn to and Subscribed before me
this 22nd day of July, 1970.

/s/ James E. Young, Jr.
Notary Public
JAMES E. YOUNG, JR.
Notary Public,
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT F

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before Me, a Notary, appeared the undersigned, Mary Jones, who declared under oath that:

1. I am a female, 44 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is 3719 Benefit Street, Apt. B, New Orleans, Louisiana where I live with my disabled husband, and thirteen of my fourteen children.

3. My family income is derived from a monthly welfare check totaling $263 and monthly social security checks for my husband and my children totaling $148. My family does not have any other sources of income.

4. I am suffering from an acute kidney condition, high-blood pressure, obesity, excess fluids and extreme nervousness.

5. I am eligible to receive treatment for my condition at Charity Hospital. For several years, I have been going to Charity Hospital for treatment with my most recent visit made in January, 1970. Several times I have asked to be admitted into the hospital, but each time I have been given pills for my kidney infection, nervousness, and high blood-pressure and then told to return home.

6. My condition has worsened in the past few days and hoping to be admitted into a hospital, I decided to go to Sara Mayo Hospital on the recommendation of a friend. I did not go back to Charity Hospital, because

I feared they would once again give me some pills for my ailments and then send me home. The drugs they have given me at Charity Hospital have not helped my condition.

7. On June 29, 1970 I went to Sara Mayo Hospital and there I spoke to a clerk at the admitting desk. I told her I was ill and that I wished to see a doctor. I also told her that I was unable to pay any physician's or hospital fees because of my meager income. The clerk told me that there was no physicians on duty at the hospital, but if I paid a deposit due immediately she would phone a physician who would see me. Since I had absolutely no money to pay the deposit, I left Sara Mayo Hospital without being examined or treated for my condition.

8. I am a very sick woman. The drugs given to me at Charity Hospital have been of no help. I feel that I should be admitted into a hospital for proper treatment of my condition.

/s/ Mary Jones
MARY JONES

Sworn to and Subscribed before me
this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public,
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT G

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

BEFORE ME, a Notary, appeared the undersigned, Shirley Lampton, who declared under oath that:

1. I am a female, 29 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is at 2526 Mazant Street, Apartment E, in the Florida Housing Project of the Housing Authority of New Orleans. I live there with my seven children for whom I am sole support.

3. My family income is derived from a monthly welfare check totaling $137 per month. My family does not receive any other source of income.

4. I am suffering from severe and at times unbearable stomach pains.

5. I am eligible to receive treatment for my condition at Charity Hospital. During the last week the pains in my stomach became more severe and I decided to go to Charity Hospital on the evening of July 6, 1970. I spoke to a physician there who only examined my urine and told me to come back if the pains became worse. The pains in my stomach continued to grow worse and I returned to Charity Hospital the next evening, July 7, 1970. At that time I was examined and given some drugs for my stomach.

6. I believe that my stomach pains have resulted from female troubles and that I need a thorough examination and possibly an operation to stop these pains which continue to plague me.

7. I fear that I wasn't receiving adequate treatment at Charity Hospital because of overcrowded operating rooms and insufficient blood supply for elective, but necessary surgery, I decided to go to Mercy Hospital, 301 North Jefferson Davis Parkway to see if I could undergo an examination in order to help cure my abdominal disorder. On July 9, 1970 I went to Mercy Hospital's information desk and asked if I could see a doctor. The receptionist told me to go to the emergency room. I went to the emergency room and spoke to a nurse there. I told her I was ill and wished to see a doctor. I also told her that I was poor and could not afford to pay for any hospital costs. She told me that in order to be seen at Mercy Hospital, I would need my own doctor or if I had a sufficient amount of money, she would call a doctor for me. She said if you have no money, you must go elsewhere. Being without money, I left Mercy Hospital without being examined.

8. I am a desperately sick woman. I fear that I will need more treatment including a possible operation for my condition. The treatment I received at Charity Hospital has not cured my illness. I do not know where to turn.

/s/ Shirley Lampton
SHIRLEY LAMPTON

Sworn to and Subscribed before me
this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public,
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT H

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before Me, a Notary, appeared the undersigned, Wilhemenia Brown, who declared under oath that:

1. I am a female, 28 years old and black. I reside in the Parish of Orleans and am a citizen of the United States and of the State of Louisiana.

2. I reside at 1855 Whitney Avenue in the Algiers-Fischer Public Housing Project. I live there with my two children, Anthony, age 11 and Arthur, age 9.

3. Our family's income is derived from $43.00 per month under Louisiana's Aid to Dependent Children Public Welfare Program and $64 per month in support payments from my divorced husband. I have been receiving the support payments very irregularly and have been in court in an attempt to have the payments made on time. As a practical matter, my total income in the last month or two has been $43 a month. I am supposed to get a raise in my welfare grant soon.

4. I have been feeling ill recently and have had pains in my left side. I am concerned about them and have a feeling it might be a kidney infection.

5. In order to get medical treatment, I recently went with my sister to West Jefferson Hospital to seek medical assistance. We went on July 8, 1970, and upon arriving, asked to see a doctor. The receptionist first asked if we had any insurance and a private doctor. I told her that I had no insurance other than under the medicaid program and I did not have a private doctor. She said

that we could not be treated there, but she still had us fill out applications and took us to see a doctor.

6. The doctor explained to us that we could not be treated at the hospital because we did not have a private physician and because we did not have insurance and because we did not have money to pay for the services received or to pay the initial deposit.

7. Because I did not have the money, there was no way for me to get the treatment I needed at this hospital so I left.

/s/ Wilhemenia Brown
WILHEMENIA BROWN

Sworn to and Subscribed before me
this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public,
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT I

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Dr. Rob Robertson, do hereby depose and say:

1. I am a Doctor of Medicine and an intern on the medical staff of Charity Hospital.

2. On May 29, 1970, I saw the patient, Clifford Breaux, while I was working in the Admittance Room of Charity Hospital.

3. When I saw the patient, he was tremendously obese; he had 4+ edema to above knees, presacral region, abdominal wall, and both hands. There were scattered posterior basilar rales in thorax and a fluid wave across abdomen on percussion. He was slightly dyspneic at rest. X-rays were insufficient because of technical difficulties in positioning patient who was unable to stand by himself. Patient weighed in excess of 425 pounds—the maximum of the hospital scale.

4. It was my opinion that the patient should be immediately admitted to the hospital. However, due to insufficient beds in Charity Hospital, patient was not admitted.

/s/ Rob Robertson
DR. ROB ROBERTSON, M.D.

Sworn to and Subscribed before me
this 15th day of June, 1970

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public,
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT J

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Jeffrey B. Schwartz, having been duly sworn, depose and say,

1. I am one of the attorneys in the lawsuit, *Rosezella Cook, et. al.* vs. *Ochsner Foundation, et. al.*

2. In connection with said lawsuit, our law office was contacted by the family of Clifford Breaux. Subsequently, Mark Rudy, another attorney in this lawsuit, and I had several conversations and interviews with Clifford Breaux and members of his family with a view towards his becoming a named Plaintiff in this action in order that he could obtain the medical treatment he needed.

3. The attached Affidavit was prepared for use in this litigation. However, Mr. Breaux died before the attached Affidavit could be executed. The Affidavit is true and correct to the best of my information and belief.

/s/ Jeffrey B. Schwartz
JEFFREY B. SCHWARTZ

Sworn to and Subscribed before me
this 20th day of July, 1970

/s/ James E. Young, Jr.
Notary Public

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

BEFORE ME, a Notary, appeared the undersigned, Clifford Breaux, who declared under oath that:

1. I am a male, 58 years old, and black. My present residence is 2605 Philip Street, New Orleans, Louisiana. I am a resident of Orleans Parish and a citizen of the State of Louisiana and the United States.

2. I am eligible for health services provided by Charity Hospital at New Orleans. I am self-employed at Cliff and Dot's Restaurant, 2601 Philip Street, New Orleans, Louisiana. For at least the past year, I have been too ill to run the store. Because of this, the store has been operating at a loss. My wife had to give up work to run the store. We are desperately poor; we can hardly afford to subsist and certainly cannot afford the expenses of hospitalization and medical treatment.

3. I am not eligible for Medicare payments because I have not reached the age of 65. I am not eligible for Medicaid payments in the State of Louisiana, because I am self-employed and I am not receiving welfare payments, or aid to the blind, aged or disabled.

4. I can only afford to go to Charity Hospital for treatment of my condition, since because of my small income, I cannot afford the deposit required and charges assessed by most other hospitals in Orleans Parish.

5. I am suffering from extreme obesity, shortness of breath, and congestive heart failure. I have been chronically ill since 1966, and because of my condition I have had great difficulty moving around. In 1966 I was a

patient for 13 days at Ochsner Foundation Hospital where I received treatment for my condition.

6. In the past few months my condition has worsened considerably. Since May 5, 1970, I have attempted to be admitted into Charity Hospital on five different occasions. On each occasion I was not admitted into the hospital.

7. On June 1, 1970, accompanied by my brother, Paul Breaux, I went to Charity Hospital for a clinic visit. At that time, I asked the physician present if I could be admitted into the hospital because of my condition, but he gave me a prescription for drugs to treat my ailment, and told me to return to the hospital on June 8, 1970.

8. On June 8, 1970, showing no improvement in my condition, I went to Charity Hospital for my clinic visit. Once again, I was given some drugs to treat my illness and told to return home.

9. On June 10, 1970 my condition became markedly worse. I began suffering extreme body pains, had much difficulty breathing and was unable to digest my food. I felt that I needed immediate hospital care. My brother, Paul Breaux, attempted without success to have me admitted as a non-paying emergency patient at Alton Ochsner Foundation Hospital, Touro Infirmary, and Flint-Goodridge Hospitals. I did not attempt to be admitted into Charity Hospital, since I had been previously refused admittance several times at that hospital and I did not want to risk further harm to myself by making a futile trip to Charity Hospital.

10. During the night of June 10, 1970 and early morning of June 11, 1970 I suffered a further relapse in my condition. My situation becoming more desperate, my brother, Paul Breaux, and my wife, Dorothy, managed to borrow the $200.00 needed as a deposit in order to be admitted into Alton Ochsner Foundation Hospital.

11. I am presently an in-patient at Oschner Hospital. I am financially unable to pay any of the costs for my treatment at this hospital.

12. I am a chronically ill man, and I am in need of hospital care in order to receive the necessary treatment for my condition.

13. Even after I am released from Ochsner, I will need continuing medical care which I will not be able to get because of my poverty.

[Unsigned]
CLIFFORD BREAUX
2603 Philip Street
New Orleans, Louisiana 70113

Sworn to and subscribed before me
this —— day of ———, 1970.

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before me, a Notary, appeared the undersigned, Edward Booker, who declared under oath that:

1. I am a male residing in the Parish of Orleans at 2805 Clara Street, Apartment F. I am a citizen of the State of Louisiana and the United States.

2. I am the son of Mrs. Catherine Booker, (deceased), whom I resided with at 2805 Clara Street, Apartment F, New Orleans, Louisiana, before her death at age 47.

3. Before her death, my mother suffered from an acute chronic asthma condition, congestive heart failure, high blood pressure, and a nervous disorder. Further, she suffered from extreme obesity, weighing nearly 300 pounds at her death.

4. My deceased mother, Catherine Booker, was eligible for treatment at Charity Hospital. She was a welfare recipient, and being desperately poor, she was forced to go to Charity Hospital as the only means to receive the necessary treatment for her condition, since she could not afford the required deposit and costs for needed treatment at other hospitals in Orleans Parish.

5. For several months prior to her death, my brothers Alfred Booker and John S. Booker, III and I attempted to have my mother admitted into Charity Hospital. During that time her condition had worsened considerably; she complained of severe stomach pains, shortness of breath, and because of her weight problem, she had much difficulty moving about. I took her to Charity on the following days: October 16, 1969, December 20, 1969, February 19, 1970, March 8, 1970, and March 22, 1970.

Each time I took my mother to Charity Hospital, she was refused admittance, and I was forced to take her home, since neither my brothers nor I could afford to take her to another hospital. During her last few months of life, my mother visited some private physicians who stated that they thought that she should be admitted into a hospital.

6. During the early morning hours of March 23, 1970 my mothers condition took an abrupt turn for the worse. She had extreme difficulty breathing and at 4:00 A.M. I took her to Charity Hospital, but again she was refused admittance and told to go home. Believing my mother to be near death, later that morning, I called Flint-Goodridge Hospital to see if I could have my mother admitted there. I explained to the clerk that my mother was gravely ill and needed immediate care and that the little treatment given to her at Charity Hospital had not helped her. The clerk said a $325 deposit and the recommendation of a physician was needed before my mother would be admitted into Flint-Goodridge Hospital. I told her I couldn't afford to pay the deposit but she said this was a required amount and no exceptions would be made. I then attempted to borrow some money in order that I could have my mother admitted into Flint-Goodridge Hospital. I was unsuccessful in borrowing the money needed to have her admitted into Flint-Goodridge Hospital.

7. My mother's condition continued to worsen and in the afternoon of March 23, 1970 I again took my mother to Charity Hospital. I attempted to have her admitted twice during the afternoon, but each time she was refused admittance because of the lack of available beds at Charity Hospital.

8. On the evening of March 23, 1970, I decided to call Charity Hospital and attempt to have an ambulance from

that hospital take my mother back to the hospital. At this time, my mother was desperately gasping for breath and seemed to be semiconscious. The ambulance came and my mother was administered oxygen and told to walk down to the ambulance, since ambulance drivers supposedly do not carry patients up and down stairs.

9. My mother accompanied by my brother, Alfred Booker and John S. Booker, III, and my sister Merian Booker went to Charity Hospital by ambulance on the evening of March 23, 1970. I was too upset over my mother's condition and my futile efforts to get her proper treatment and thus couldn't accompany my mother to Charity Hospital. My mother was finally admitted into Ward E-508. She was given a larger tank of oxygen, but her condition continued to worsen; she could no longer speak and had great difficulty breathing. She died in the early morning of March 24, 1970 about one hour after finally being admitted into Charity Hospital.

10. I firmly believe that if given the proper treatment, my mother would still be living today. Since my mother was desperately poor, she could not afford to receive treatment at any other hospital except for Charity Hospital, where the treatment she received was both too little and too late.

/s/ Edward Booker
EDWARD BOOKER

Sworn to and subscribed before me
this 20th day of July, 1970.

/s/ James E. Young, Jr.
Notary Public

AFFIDAVIT OF DR. ALBERT J. LAURO

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Albert J. Lauro, being duly sworn did depose and state as follows:

1) I am a Senior Staff Supervisor of the Acute Emergency Room at Charity Hospital of Louisiana in New Orleans.

2) Credentials are as follows:

Louisiana State University School of Medicine—M.D. Degree, 1951

Internship at Mercy Hospital 1955

Residency in Internal Medicine at Charity Hospital of Louisiana at New Orleans 1956-1958

Visiting (Sr.) physician and parttime staff, Charity Hospital of Louisiana at New Orleans, 1958-1969

Louisiana State University School of Medicine: Instructor 1956-1958

Assistant Professor of Medicine 1958 to date

Private practice—parttime until 1969

3) As one of the six Senior Staff Supervisors of the Acute Emergency Service at Charity Hospital. I supervise the interns and residents assigned to that service and the decisions which each must make on whether a patient gets admitted on inpatient status or treated on ambulatory basis. In a borderline situation, I personally have the responsibility to make the decision as to whether to admit a patient.

4) Approximately 35 to 50 patients a day get referred to outpatient clinics for treatment, who, in my opinion and based upon my experience as a private practitioner in New Orleans, would get admitted as inpatients at private hospitals and would be admitted to Charity if we had the facilities.

5) For approximately a year (during 1970) records were periodically made documenting patients who were referred to ambulatory (outpatient) treatment rather than admitted as inpatients. Since then, we have made spot checks, and from these spot checks and my personal knowledge and experience of the acute emergency service, the number of patients who are not admitted as inpatients who would be admitted with similar conditions at private hospitals is approximately the same today as when the periodic records were kept.

6) For example, on Sunday, April 16, 1972, I made a spot check of the persons classified as "elective" surgery who were turned away from inpatient admission who should have been admitted. There were 26 such cases, including one with masses of the breast and one with gallstones. On this particular day there were already five patients on roller beds in the surgical ward causing severe overcrowding and consequently no additional patients were admitted.

7) Some of the common types of cases which are not given inpatient care who should, in my professional opinion, be admitted but are referred to ambulatory treatment are:

a) stroke victims: Many persons suffering from strokes are not admitted but are sent home with symptoms such as weakness in an arm. Three days later some of these patients will come back with full paralysis on one side. I would always admit such a patient for 72 hours observation in the private practice situation and

under these inpatient conditions might well be able to prevent adverse developments;

b) impending infarction (impending heart attack): It is very unfortunate to have to send such persons home but under the overcrowded conditions at Charity it occurs;

c) ulcers: Not actively bleeding, but with anemia;

d) masses in the lung (which may be cancer or TB);

e) uncontrolled hypertension with blood pressure over 200/Over 140. Such patients are given an injection on a roller bed and watched possibly for 24 hours and then sent home without being admitted into inpatient status. We do not know if the patient soon thereafter would go into shock or whether his or her blood pressure shoots back up.

These are the conditions I see every day; there are others.

8) There are many things lost to a patient who is given ambulatory treatment and then sent home rather than be admitted as an inpatient;

a) there is a delay in diagnosis, which may be critical;

b) his treatment is not being supervised, e.g., the effects of medicine upon his system is not under surveillance for 24 hour periods if he is not an inpatient;

c) the patient may have adverse reaction but have a problem getting an ambulance and not come to the hospital;

d) poor people may be better off in a hospital because of communication problems concerning effects of treatment.

9) One of the critical problems is the shortage of beds. In many instances halls are used as wards with patients

in roller beds. Some interns and residents have patients they are treating that are scattered all over the facility and this decreases efficiency and in emergency situations can be extremely detrimental to the patients health.

10) The private hospitals in the New Orleans area had bed shortages prior to 1969, but things have been greatly improved since Methodist opened and West Jefferson increased substantially the number of beds. As of 1969, I was able to place my private patients in Mercy (where I had staff privileges) whenever I called for space. Comparably, things are worse at Charity from what they were in 1969 with respect to available beds for persons needing inpatient admission.

11) In addition to the patients whom we cannot admit from the emergency room there are patients we do admit, but once they get transferred to the wards they are released by the resident in charge in the ward because of serious overcrowding in the ward. On one occasion this past winter I had to threaten a resident with sanctions if he did not admit a patient into his service whom we had admitted. These residents are under a severe strain since they no more want to turn persons away anymore than we do, but they have a severe shortage of space. Dr. Jaime Olle, for example, has a 12 bed assignment, but in fact has 46 patients scattered throughout the hospital.

12) Some four or five months ago, I personally called Dr. Hyman at Sara Mayo and the administrator at South Jefferson Hospital and asked them to take some Medicare patients and forget the deductible. Both said they would be unable to do it. I had intended to call all the private hospitals with a similar request, but after these two hospitals looked into the matter and stated

they were unable, I felt it would be fruitless to call any others.

/s/ Albert J. Lauro
DR. ALBERT J. LAURO

Sworn to and Subscribed before me
this the 31st day of May, 1972.

/s/ [Illegible]
Notary Public

AFFIDAVIT OF DR. ROD YEAGER

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Rod Yeager, being duly sworn, did depose and state as follows:

1. As of July 1, 1972, I became head of the Section of Cardiac Surgery at Louisiana State University Medical School in Shreveport, Louisiana. I have the title of Assistant Professor.

2. Prior to July 1, 1972, I was the Chief Resident of Thorastic Surgery at Charity Hospital of Louisiana at New Orleans.

3. My credentials are as follows:

Tulane Medical School, M.D. degree, 1965

Internship at Charity Hospital of Louisiana at New Orleans 1965-1966

Surgery Resident for six years at Charity Hospital of Louisiana at New Orleans 1966-1972

Chief Resident—Tulane General Surgery 1970-1971

Chief Resident of Thorastic Surgery 1971-1972

4. From my experience as a resident in surgery at Charity Hospital, the shortage of bed capacity has meant that many persons needing elective surgery cannot get into the hospital, or get into the hospital in very limited numbers after a long wait.

5. The conditions which I include in elective surgery are such conditions as the following: hernia, ulcers (peptic), gall bladder, varicose veins, hysterectomies, breast masses (which may or may not be malignant).

6. The failure for these patients to be admitted means that they are in constant "misery" and, in many cases, cannot work and must remain on welfare. An example of the letter are cases of hernia which render men disabled and place them on the welfare roles; if these men could get the operation (which is elective) they could go back to work.

7. The surgery service from which I supervised has four residents in addition to the supervisor. These residents keep a list of "pre-operative" patients, i.e., patients who have been worked up in clinic and are ready for elective surgery, but have not been admitted for the surgery because of lack of beds. From my experience at any given time each of the residents will have at least 20 patients in this category.

8. On June 29, 1972, I met with Marilyn G. Rose, one of the attorneys for the plaintiffs in the case *Cook et al.* vs. *Ochsner Foundation Hospital, et al.* After explaining the above problems to her, I called one of the residents who worked under me to the office at Charity Hospital and asked him to look at his pre-operative list and tell us how many patients on that list were awaiting admission for elective surgery. He counted 60. He had the Charity record numbers of 50 of these patients listed. This resident's name is Dr. Max Kappelman, a third year resident in surgery. From my experience as a surgery resident and as Chief surgery supervisor, the conditions of these patients and the period which they had been awaiting surgery would be representative of the records of all the residents for at least the last two years.

9. The private hospitals in the New Orleans area transfer patients to Charity Hospital. When a patient who has been operated upon, usually because of trauma, at the other hospital, the transfer may be a medical problem. In certain circumstances the practices and pro-

cedures followed at the other hospital may be different from those which we would have followed at Charity. (This difference is not a difference in quality, but a difference in approach). The difference affects the continuity of treatment. In addition the medical workup and history is often lacking of incompleteness. Delays in treatment result from the disruption of treatment and the incompleteness of the record, and this can be medically detrimental to the patient.

10. Twice within recent months a patient in trauma was operated upon in another hospital where he arrived in an emergency condition and then transferred from the recovery room to Charity Hospital.

DR. ROD YEAGER

Sworn to and Subscribed before me
this —— day of June, 1972

Notary Public

AFFIDAVIT OF DR. CHARLES C. MARY, JR.

I, Charles C. Mary, Jr., being duly sworn, did depose and state as follows:

1.) I am Director of Charity Hospital of Louisiana in New Orleans, having been appointed to that position effective January 1, 1970.

2.) Credentials are as follows:

Loyola University of the South—B.S. Degree—1958

Louisiana State University of Medicine—M.D. Degree—1961

Tulane School of Public Health (Medical Administration) 1969

Director of Professional Services at Charity Hospital—1969

Director of Medical Education and Charity Hospital Schools—1968

Director of Medical Intensive Care Unit at Charity Hospital—1966-68

Associate Director of Charity Hospital—1966-69

Assistant Clinical Director of Charity Hospital—1964-65

3.) As Director of Charity Hospital, I am the chief operating officer of the hospital, with final responsibility for carrying out the hospital's mandate to provide medical care to the indigent of Louisiana.

4.) The medical services available to the indigent population of the New Orleans Metropolitan area, which consist overwhelmingly of services provided by Charity Hospital, fall markedly short of meeting the health needs of this indigent population. The reasons for this failure

are lack of funds with resulting lack of personnel and a limitation of physical facilities.

5.) Despite these deficiencies in faculties, those patients that Charity Hospital does in fact serve do receive good quality of care. This high quality of care is a direct result of the excellent medical staff, which includes professors and teachers at Louisiana State and Tulane Universities Schools of Medicine and Louisiana State School of Dentistry. However, the main thrust of Charity Hospital's efforts in caring for the poor is crises intervention and treatment of acute and chronic illnesses. Limitations in facilities and overwhelming numbers of patients with acute illnesses have to date prevented adequate comprehensive programs in preventive medicine, eye, dental and health education. In the past two years, 1970-72, there have been increasing numbers of indigent patients seeking care from Charity Hospital. Outpatient visits in:

1970—813,000 visits
1971—854,000 visits
1972 projected—980,000 visits

In order to maintain the high level of inpatient care and to keep up with increasing costs of hospitalization, the hospital was forced to reduce beds in 1970 which has resulted in patients being denied admission and being treated as outpatients. Charity Hospital has been forced during the time of my tenure, including to the present date, to refuse inpatient care to an average of 20 to 25 patients per day and as high as 50 patients on certain days. This determination regarding care and treatment is based on option of medical officers using admission standards of a private hospital.

6.) Charity Hospital is forced to render outpatient care in overcrowded and overtaxed facilities where every seat is taken and standing room is not unusual.

7.) In addition, with respect to outpatient facilities, the limitation in the number of examining rooms results in make-shift arrangements at which patient privacy is at a premium. With respect to inpatient services, frequently patients who are admitted are placed on roller beds because of the lack of available hospital beds.

8.) As set forth above the existing medical services in the New Orleans metropolitan area fall short of meeting the needs for services requested by the poor presenting themselves for treatment. This, however, is only a portion of the actual medical services needed by the poor. If medical services were made available substantial additional poor people would receive treatment and consequently be healthier and more productive citizens.

9.) One example of documenting this statement was the extensive demand and unexpected inundation of a conveniently placed satellite clinic in the Desire area. In 1969 Charity Hospital opened an outreach clinic in the Desire Project Area in the Ninth Ward of the City of New Orleans. This clinic is open in the afternoons on Monday through Friday and at the present time serves 1,200 patients per month. In spite of this additional service, many more patients seek service in the clinic than can adequately be handled at the present time and expansion of services in this area is necessary. Additional satellite clinics have further demonstrated that there are large numbers of indigent patients who do not seek care at the main facility, perhaps because of reason of inconvenience of distance, time and family responsibilities as well as inaccessibility of care and low awareness amount the poor of the value of preventive and early health care.

10.) Another example of unmet health needs in the Desire Project Area is the fact that on many occasions in the past three years children with diptheria were ad-

mitted to Charity Hospital. This disease is totally preventable and good programs of preventive medicine and health education could entirely eliminate such occurrances.

11.) It is also our experience at Charity Hospital that the instances of certain diseases among the poor such as tuberculosis and cervical cancer is higher than in the non-indigent population. With additional funds for further facilities Charity could construct outreach clinics, could expand its presently overcrowded outpatient and emergency facilities, and could add the additional needed beds to serve the needs of the metropolitan New Orleans area.

12.) On a recent inspection by the Joint Commission for Accreditation of Hospital, Charity Hospital was given a full two year accreditation. However, the major criticism of the site visit was the overcrowding of the inpatient and outpatient facilities of this institution.

/s/ Charles C. Mary, Jr., M.D.

Sworn to and subscribed before me
this 21st day of April, 1972.

/s/ [Illegible]
Notary Public

AFFIDAVIT OF RAYMOND DOWNS

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Raymond Downs, being duly sworn, did depose and state as follows:

1. I am the Assistant to the Director of Charity Hospital of Louisiana at New Orleans.

2. On June 29, 1972, Dr. Max Kappleman, a third year resident in surgery at Charity Hospital gave to me a list of the record numbers of 50 patients. This was done at the direction of Dr. Rodrick Jaeger, Chief Resident, Tulane Surgery.

3. Upon the request of Marilyn G. Rose, attorney for the plaintiffs in *Cook* v. *Ochsner*, I directed Mrs. Eddie Cooksey, who is in charge of the record room at Charity Hospital to have someone under her supervision check the records of these patients to determine the condition for which each patient was waiting surgery and how long each patient had been so waiting.

4. The records were examined by extern Wayne Green and summaries are attached hereto and made part of this affidavit.

RAYMOND DOWNS

Sworn to and Subscribed before me
this —— day of July, 1972.

Notary Public

CHARITY HOSPITAL OF LOUSIANA

AT NEW ORLEANS

Progress Notes

T64-86139 Colostomy Stricture

In Med. Clinic Dec. 21, 1955—1st indications of rectum pains. Followed in Procto Cl Jan. 18, 1956 admitted for surgery.

Diagnosis—Adenocarcinoma of Rectum.

Operation—Abdominal perineral resection.

In Gen. Surgery Cl *Jan. 17, 1962*—diagnosis of colostomy stricture.

T62-6893 Breast Mass

In Gen. Surg. Cl *March 7, 1972* for evaluation of ® Breast Mass.

T63-34865 Gallstones

In Med Cl, *April 11, 1972*—it was noted that she had a history of gallbladder disease—symptomatic now. Has a gallbladder visualization on 5-24-72—impression cholelithiasis.

752-79575 Lipoma

In C704 10/24/52 with diagnosis of chronie ® humenis osteomyelitis.

In Ortho Cl *Oct. 9, 1961*—notation of lipoma on back.

T51-32918 Hernia

Seen in Acc Room on *4-13-72*—Diagnosis as Umbilical Hernia. In Gen. Surg. cl 4-27-72, diagnosis—same.

T51-32274 Lipoma

In Gen. Surg. Cl—*Sep. 10, 1951* with a diagnosis of lipoma of rt. flank. On 9/27/51 in Gen. Surg. Cl—had lipoma removed.

In Acc. Room *2/23/72*—diagnosis of lipoma of neck. In Gen. Surg. Cl 3/2/72—diagnosis as same.

665-102406 Anal fistula

On paper you had T65-102406—probably a wrong number. Patient had no diagnosis of anal fistula.

T65-99373 Gall Stones

On Jul. 15, 1953, patient had a normal cholecystogram. On 3/2/72 pt. had an oral cholesystogram with a diagnosis of cholelithiasis. In Med cl, *2/24/72*—had a oral GBU series, gallstones were in question.

T65-112872 Diverticulitis

In Gen. Surg. cl on *3/9/65*—had a Barium Enema—revealed diverticulae in caecum and transverse colon.

On 5/2/71—admitted to D710 for callus ft. Discharge Summary noted diverticulosis of sigmoid colon.

T66-125248 Colon Polyps

Pt. has been followed in cl since *1967* with possibility of colon polyps. He has been admitted for Ca of the prostate and has a history of Pagets disease.

T54-145198 Gall Stones

Pt. has been followed for transitional cell Ca of the ® kidney. Pt. had a cholecystogram done on 9/28/66 with a normal impression. In accident Rm on *6/5/72* with a diagnosis of choletithiasis. In general Surg. cl on 6/15/72 with same diagnosis.

T55-168252 Breast Mass

Pt. came to Accident Rm on *5/10/72* with a diagnosis of breast mass. Was in General Surg. cl on 5/18/72 with the same diagnosis.

T55-188727 Peptic Ulcer

Pt. has been followed from 1958 for pain in Right Upper Quadrant. Recently pt. was seen in Accident Room with a diagnosis of a possible peptic ulcer on *3/14/72*. Has been followed in Gen. Surg. and Ural. cl.

T68-190581 Lipoma

Pt. in General Surg. cl. on *4/6/72* with first diagnosis of lipoma.

T68-197061 Breast Mass

Pt. in Gen. Surg. cl on *3/9/72* what it states that a ® Breast mass was noted on Dec., 1971. Has been followed in clinic since.

T55-190970 Breast Mass

Complete chart in file.

Was in Gen. Surg. cl. on 7/9/71 for removal of popilloma from ® breast, no masses then.

In Gen. Surg. cl on *4/13/72*—notes that one month ago nodule found in Rt. Breast. followed in cl. since then.

T54-153922 Breast Mass

Pt. in Gen. Surg. cl *1/27/72* with a diagnosis of fibroadenoma of (L) Breast.

T45-180486 Breast Cyst

Complete chart not in file.

Pt. was in Acc. Room on *4/3/72* with a diagnosis of rt. breast tumor. In Gen. Surg. cl 4/6/72 diagnosis as rt. breast mass.

T55-190840 Lipoma

Pt. in Gen. Surg. cl on *4/13/72* for liposarcoma of back. Was admitted on 4/19/72 to W711 and lipoma was excised.

T68-191224 Breast Mass

Pt. referred from Family Planning with symptoms of small lump of L breast on *5/8/72*.

Seen in Gen. Surg cl. on 5/11/72 with diagnosis of ill defined L breast mass.

T70-232201 Hemorrhoids

Pt. was seen in Acc. Room on *12/2/71* and 12/3/71 with a diagnosis of external hemorrhoids. Was seen in

Procto Surg. cl on 12/13/71 with a dx of internal hemorrhoids.

T56-219256 Ganglion

Pt. was in Gen. Surg. cl 6/8/72. Was stated that pt. had a two month history of a cystic mass on the L foot. First noted on *6/1/72* when seen in Acc. Room.

T69-225105 Umbilical Hernia

Pt. was seen in Acc. Room *3/1/72* and 3/6/72 with same diagnosis of umbilical hernia. Was seen in General Surg. cl. with diagnosis of Umbilical hernia on 3/23/72.

T69-225837 Breast Mass

Pt. was seen in Gen. Surg. cl on *11/4/71* with a diagnosis of fibroadinoma of the ® breast.

T70-244780 Hernia

Pt. was seen in General Surg. Cl. on *5/6/71* with a diagnosis of vestical hernia.

T70-236335 Hernia

On *2/29/72* Pt. was seen in Acc. Rm. with a diagnosis of indirect inguinal hernia. Seen in Gen. Surg. cl on 3/2/72 with a dx of ® Femoral hernia.

T70-238488 Carotid Artery Stenosis

Admitted 1/21/71 with a dx of carotid artery stenosis. An carotid endarterctomy was performed. Was seen in Gen. Surg. cl on *4/22/71* with a dx of carotid stenosis.

T71-256190 Gallstones

Was admitted on *3/12/72* with a dx of Pancreatitis and cholecystitis. Has been followed in Gen. Surg. cl with a dx of cholecystitis.

T71-256898 Hernia

Pt. was in M.G.N. cl. on *4/16/71* with a dx of (L) Inguinal hernia. Admitted on 6-14-72 with the same diagnosis. An inguinal hernia repair was done. Discharged 6/19/72.

T71-261607 Lipoma

Pt. was seen in Ortho cl. on *1/3/72* with an accompanying dx of lipoma. Was in Acc. Room on 2/7/72 with same dx.

71-268369 Breast Mass

Pt. was sent from family planing with lump in (L) breast. Was seen in Gen. Surg. cl. on *9/20/71* with same diagnosis.

T57-276529 Breast Mass

Pt. was seen in Acc. Rm on *12/18/71* with dx as fibroadenoma. In Gen. Surg. cl on 1/13/72 with same dx.

T60-367578 Lipoma

Pt. seen in Gen. Surg. cl. on *2/10/72* with a clinical diagnosis of a lipoma on his back.

T72-284999 Colostomy Closure

Pt. was admitted on *2/14/72* to E408 with a dx of adenoiarcinoma of the colon. A colostomy was performed then. Pt. is being followed in Gen. Surg. Cl.

T72-287760 Breast Mass

Pt. was seen in Acc. Rm. on *3/13/72* with a dx of fibrocystic disease of both breasts. Seen in both General Surg. cl on 3/23/72—says pt. has masses in both breast for at least 4 months.

T71-278730 Breast Mass

Pt. seen in Gyn. cl. on *1/20/72* with a dx of fibroadenoma left breast.

T71-272453 Cholecystitis

Pt. was seen in Gen. Surg. cl. on *4/4/72* with a major dx. of cholecystitis. Pt. is blind and also a diabetic.

T50-423819 Gallstones

Complete chart not in file.

Pt. seen in Acc. Room on *5/4/72* with a dx of GB disease. Seen in Gen. Surg. cl on 5-16-72 and had a

GB visualization. There were some indication of gallstones. Had a cholecystogram with definite evidence of gallstones on 6-6-72.

T72-289206 Inguinal Hernia

Pt. seen in Gen. Surg. cl on *2/10/72* with a dx of ® inguinal hernia. Admitted on 4/12/72 to E807 with a dx of ® inguinal hernia and benign prostrate hypertrophy. Admitted on 5/15/72 with a dx of ® inguinal hernia and Upper GI Bleeding. An inguinal hernia repair was done.

T59-318681 Hemorrhoids

Pt. seen in Gen. Surg. cl. on *3/2/72* with a dx of hemorrhoids.

T48-327652 Lipoma

Pt. seen in Gen. Surg. cl. on *8/21/71* with a dx of a large lipoma.

T72-287747 Colon Cancer

Pt. seen in Acc. Rm. on *3/21/72* with a dx of R/O Ca Colon. Pt. admitted on 5/2/72 to W711 with a dx of benign adenomatous colonic polyp.

T61-385555 Varicose Veins

Complete chart not in file.

Pt. admitted to Obst ward on *5/3/72*. During P.E. varicose veins were noted.

T72-294236 Hemorrhoids

Pt. came to Acc. Rm. on *6-19-72* with a dx of external hemorrhoids. Pt. was seen in General Surg. cl. on 6/22/72 with a clinical dx of external hemorrhoids.

T72-287752 Breast Mass

Pt. seen in Acc. Rm. on *3/21/72* with a diagnosis of a L Breast mass. In Gen. Surg. cl on same date with dx of fibroadenoma of L breast.

T72-286883 Breast Mass

Pt. was seen in General Surg. cl on *4/6/72* with a dx of breast mass in both R & L.

M C of L65-91906 Hemorrhoids

Probably wrong number.

T51-23729—no chart in file. Lipoma

EXHIBIT 15

HEALTH INSURANCE INSTITUTE

277 Park Avenue, New York, New York 10017

March 1, 1973

Mr. Mal Schechter, Senior Editor
Hospital Practice for the Staff
and Community Physician
1230 National Press Building
Washington, D.C. 20004

Dear Mr. Schechter:

This is in reply to your questions about the *1972-73 Source Book of Health Insurance Data.*

The hospital, surgical, regular medical, and short-term disability income coverage figures were revised for 1965-1970 in the 1972-73 *Source Book.* This revision was noted in the text on page 17 and in the footnotes of each table that appears in the book.

In answer to your second question about benefits to coverage ratio for insurance companies versus Blue Cross, Blue Shield, insurance companies offer a wider choice of benefit patterns to employes and individuals than Blue Cross, Blue Shield. Insurance company plans are as broad, and broader than Blue Cross, Blue Shield but many are smaller, and it depends on the purchaser of the plan and his needs. Smaller payments bring the average size payment down in size.

Out hospital expense benefits for daily hospital room and board are for group in force. Group insurance coverage represents 74% of all insurance coverage. Some of these people also have individual coverage. Some 27% of employees covered under basic hospital expense

policies with no supplementary major medical policy had under $25 coverage of the ward or semi-private daily hospital room and board rate. There were 10% with supplementary major medical.

Some 58% had $50 and over coverage under basic hospital expense policies with no supplementary major medical policy; 49% had it with supplementary major medical.

Please let us know if you have any other questions.

Sincerely,

/s/ Rosemarie Shomstein
Rosemarie Shomstein
Senior Research Assistant

RS:sll

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

[Title Omitted]

STATEMENT OF MATERIAL FACTS
NOT IN DISPUTE

[dated April 10, 1973]

1. The Internal Revenue Code of 1954 provides certain tax benefits and exemptions for institutions classified under the provisions of the Code as "charitable," to wit: institutions which qualify as charitable are exempted from payment of Federal income taxes by virtue of 26 U.S.C. 501(c)(3); contributions to such institutions are deductible from gross income on individual and corporate income tax returns by virtue of 26 U.S.C. 170(a) through (c); such institutions and donors to such institutions are also eligible for other Federal tax benefits and advantages under Section 642(c), 2055, 2106 (a)(2) and 2522 of 26 U.S.C.

2. As of 1970 there were 3,386 nongovernmental not-for-profit short-term general and other special hospitals in the United States. (*Hospitals*, Journal of the American Hospital Association, Guide Issue, Part II, August 1, 1971, p. 462). These hospitals are eligible to claim charitable status under the provisions set forth in paragraph 1, file the pertinent forms claiming such eligible status, and be determined as such by Defendants or their agents. A substantial number, if not all, of these hospitals do in fact claim such status, pay no taxes and their donors deduct contributions to them under the provisions set forth in paragraph 1.

3. The amount of monies which otherwise would be taxable as income to such hospitals or which otherwise

could not be deducted from taxable income by donors to such hospitals is substantial. Representative of the current amount of monies so affected are the following figures for 1969:

—In 1969 hospitals received some $2.3 billion as charitable contributions (Hearings on Medicare and Medicaid before the Subcommittee on Medicare-Medicaid of the Senate Committee on Finance, 91st Cong., 2nd Sess. 422 (1969).

—In that same year net income for all nonprofit community hospitals was $400 million. (*Net Income of Hospitals*, 1961-1969, U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, Staff Paper No. 6, p. 27). Except for 501(c)(3) and 170(c) status as "charitable" institutions, such monies would have been taxable in accordance with applicable provisions of the Internal Revenue Code.

4. Until the issuance of Revenue Ruling 69-545 (1969 Cum. Bull.), successive Commissioners of Internal Revenue had always followed the legal interpretation and policy that hospitals had to afford services to persons unable to pay in order to be eligible for status of "charitable" institutions under the Code.

5. In 1956 the Internal Revenue Service issued Revenue Ruling 56-185, which "codified" the position which it, and the courts, had taken with respect to the obligations of a "charitable" hospital to serve the poor. That Ruling stated in part that in order for a private hospital to establish that it qualified as a charity pursuant to Section 501(c)(3),

> "it must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered." Rev. Rul. 56-185, 1956-1, C.B. 202, 203.

6. In 1969 the original Defendants in this action issued Revenue Ruling 69-545, 1969 Cum. Bull., which in pertinent part provided:

> "In order for a hospital to establish that it is exempt as a public charitable organization under § 501 (c)(3) it must . . . be operated for the care of all those persons in the community able to pay the cost therefor either directly or through third party reimbursement."

In said ruling said Defendants specifically reversed Rev. Ruling 56-185 that a charitable hospital within the meaning of the Internal Revenue Code must not refuse to accept patients in need of hospital care who cannot pay for such services. The present Defendants have continued to follow such position and to permit hospitals the benefits of the provisions set forth in paragraph 1 without requiring them to serve persons unable to pay.

7. Revenue Ruling 69-545 was issued on October 8, 1969 without a notice of proposed regulations, and with-

out an opportunity for interested and/or affected parties to present their views, arguments, and opinions, and to assert facts, positions of policy, and positions of law to the original Defendants in this action. Present Defendants have continued such policies and have not afforded interested and/or affected parties any such opportunity.

8. Defendants did not follow the procedures set forth in section 553 of the Administrative Procedures Act for rule-making.

9. On May 22, 1971 a Notice of Hearing on proposed amendments to the regulations under section 170 of the Internal Revenue Code, relating to charitable contributions, appeared in the Federal Register, Vol. 36, No. 100. Individual Plaintiffs Henry and Carolyn Block, Monica Hunter, Rosezella Cook, and Shirley Lampton, and organizational Plaintiffs Eastern Kentucky Welfare Rights Organization, California Welfare Rights Organization, and National Tenants Organization, among others, filed a Statement on the definition of "charitable" hospitals under section 170 of the Internal Revenue Code, with attachments, a copy of which is attached to the Motion for Summary Judgment as Exhibit 2. On June 22, 1971, said individual and organizational Plaintiffs, represented by their counsel, Anthony Z. Roisman, testified before a hearing panel established to hear testimony under said proposed rule-making. Mr. Roisman, as set forth more fully in his Affidavit, attached to the Motion for Summary Judgment as Exhibit 3, was told that the subject of the hearing did not pertain to the matters which he raised, and that his testimony and the matters set forth in Exhibit 2 were addressed to the wrong forum.

10. Among the hospitals eligible for charitable status under the provisions of the Internal Revenue Code described in paragraph 1, and which have been accorded such status, are the following:

(a) In New Orleans, Louisiana: Roman Catholic Sisters of Mercy, Southern Baptist, Methodist Hospital, Hotel Dieu Sisters Hospital, Ochsner Foundation Hospital, Flint-Goodridge Hospital of Dillard University, Sara Mayo Hospital;

(b) In Tucson, Arizona: Tucson Medical Center;

(c) In Floyd and Pike Counties, Kentucky: Prestonburg General Hospital (legally known as Highland Hospital Corporation) and Methodist Hospital of Pikesville.

11. Individual Plaintiffs and persons who are members of and represented by organizational Plaintiffs are all persons who are unable to pay for hospital services, and some, if not all, needed such services at various times relevant hereto. (Affidavits attached to Motion for Summary Judgment).

12. "On nearly every index that we have, the poor and the racial minorities fare worse than their opposites. Their lives are shorter; they have more chronic and debilitating illnesses, their infant and maternal death rates are higher; their protection, through immunization, against infectious diseases, is far lower. They also have far less access to health services—and this is particularly true of poor and non-white children, millions of whom receive little or no dental or pediatric care." *Towards a Comprehensive Health Policy for the 1970's, A White Paper*, U.S. Department of Health, Education, and Welfare, May 1971, p. 2.

Date: April 10, 1973

Respectfully Submitted,

/s/ Marilyn G. Rose
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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil No. 1378-71

[Title Omitted]

CROSS MOTION FOR SUMMARY JUDGMENT

[Filed June 27, 1973]

Comes now the defendants herein by their attorneys and move this Court for an order denying plaintiffs' motion for summary judgment and granting summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure in favor of the defendants, George P. Shultz, Secretary of the Treasury, and Donald C. Alexander, Commissioner of Internal Revenue for the following grounds:

1. The plaintiffs lack standing to maintain this action;

2. The actions complained of herein are not subject to review by this Court;

3. The plaintiffs have failed to demonstrate that the alleged injuries complained of herein were incurred as a result of any actions on the part of the defendants.

/s/ John J. McCarthy—by JBT
JOHN J. MCCARTHY
Chief
General Litigation Service
Tax Division
Department of Justice
Washington, D.C. 20530

/s/ Jack B. Teplitz
JACK B. TEPLITZ
Trial Attorney
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APPENDIX A

AMERICAN HOSPITAL ASSOCIATION
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STATEMENT OF
JOHN ALEXANDER McMAHON
PRESIDENT OF
THE AMERICAN HOSPITAL ASSOCIATION
ON TAX REFORM
BEFORE THE
HOUSE COMMITTEE ON WAYS AND MEANS

April 13, 1973

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association which represents some 7000 hospitals throughout the country. Accompanying me is Leo J. Gehrig, M.D., the Association's Vice President for Federal Relations. I appear today to express to the Committee our concern with any action the Committee might take in connection with its current consideration of tax reform, which could jeopardize or in any way inhibit charitable contributions to the nation's voluntary nonprofit hospitals.

In ours as well as in other civilized societies the hospital is the primary instrument developed for the care of the sick and is the community center of health care. Nations have met their obligation with respect to the development of hospital facilities and hospital care in different ways. Some have developed systems which, from the beginning, have been the complete responsibility of the government. The government builds the hospitals,

operates them, and appropriates tax funds to pay for their operation. Nothing is left to the voluntary efforts of individuals. However, in the United States, a pluralistic approach has been utilized which supports the development of the voluntary nonprofit hospital.

In our publication, *Hospital Statistics, 1971*, 5,865 institutions out of a total registered hospital population of 7,097 institutions are identified as community hospitals. Of the 5,865 community hospitals, 3,363, or 57.3 percent are voluntary nonprofit hospitals. These nonprofit hospitals, while representing only 57 percent of all community hospitals, nevertheless have 70 percent of the total community hospital beds. In 1971 they admitted more than 21 million persons for inpatient care, or 71 percent of all admissions to community hospitals in the nation. Moreover, they provided services through more than 100 million outpatient visits, 70 percent of the total outpatient care provided by community hospitals. These statistics show conclusively that the nonprofit voluntary hospital is the backbone and strength of our community hospital system.

Voluntary nonprofit hospitals are, in varying degrees, dependent upon charitable contributions made by a generous public. Most were originally organized and constructed, partially or totally, through such resources. And they have continued to rely on charitable contributions in meeting the costs not only of construction and equipment but also in the financing of research, education, and general operations which have become increasingly expensive.

Only four years after the initial enactment of the first income tax act, the Congress recognized that the charitable contribution removed a burden from government. This recognition resulted in an encouragement to the generous impulses of society by giving individuals a

deduction from taxable income for their support of religious, charitable and educational activities. Until recent years, the changes in income tax provisions were in the direction of further encouragement to these benefactors of the community rather than moves to discourage their philanthropic impulses.

Section 170 and 501(c)(3) of the Internal Revenue Code are recognition on the part of the Federal government that nonprofit hospitals render a substantial benefit to the community in making hospital facilities and services available as a function in the public interest which would otherwise have to be fulfilled by government at tax expense. A basic incentive to the donations spelled out in the IRS Code are tax benefits and income tax deductions which have been granted by the states since the inception of the Republic and by the Federal government following the enactment of the Federal income tax laws.

Fundamentally, such provisions in the law arose from public needs and the public's recognition of the essential function of the voluntary nonprofit hospital. The public also recognized in supporting such laws that hospital service was an essential function which must be discharged, if not by voluntary agencies, then by government.

The charitable deduction is not a loophole. It differs from most other deductions and tax preferences in that it is not economically motivated. Other deductions inure to the individual taxpayer's benefit. However, the donor would be economically ahead by not making a charitable gift because the tax savings would always be less than his contribution. Charitable contributions are voluntary and benefit the nation as a whole. Any reduction of current incentives to charitable contributions or a transfer tax on a gift or a bequest to charity would, in

effect, be an indirect tax on publicly supported charitable organizations.

Moreover, voluntary charitable contributions have offered the means of maintaining the historical balance between government services and voluntary initiatives. The charitable contribution deduction enables citizens to participate in making decisions rather than to concentrate greater power in government.

We also believe strongly that existing tax preferences for such donations are the single most important incentive for people to continue to support charitable enterprises. In a recent decision * involving tax preferences, Judge Edward Allen Tamm of the United States Court of Appeals for the District of Columbia made the point that the tax deduction motivates charitable contributions. We think this is self-evident.

We recognize, of course, that the Committee is considering a number of proposals that would revise the system of tax preferences for charitable contributions for various reasons, including a more equitable distribution of the tax preference and a more efficient administration of the tax laws. However, we believe the present partnership relation between government and the private sector is clearly advantageous to the Federal government and should be retained.

In the document entitled "Giving, U.S.A.," the American Association of Fund-Raising Counsel, Inc., has compiled facts and cited trends in American philanthropy for the year 1971. That Association's computations disclose that during 1971 total charitable giving came to $21.15 billion, of which $3.4 billion was donated to the health and hospital field. Significantly, 71.4 percent of this total giving came from individuals.

---

* "Americans United" Inc., et al v. Commissioner of Internal Revenue, No. 71-1299, January 11, 1973.

We have recently surveyed 3,530 voluntary nonprofit hospitals located in the United States. At an initial cut off of returns in order to provide you with statistics at this time, a total of 891 responses, just over 25 percent, were received. These 891 institutions reported total voluntary support of $181 million in 1972. A projection of this initial response arithmetically over the entire field, would indicate one year's contributions to voluntary nonprofit hospitals of about $800 million. Approximately 70 percent of this amount represents outright gifts, the remainder being divided, 25 percent from bequests and 5 percent from deferred gifts. Further, more than half of the total amount represents contributions by individuals.

If this source of funds were to disappear from the hospital financing picture, it would have to be replaced. I think it is obvious where the hospital field would have to go for that replacement—government and hospital patients. In the interim, after the voluntary source of funds had disappeared and until the government could recognize its obligation to replace them, serious hardships would occur among the patient population in hospitals and to the hospital service industry. To the extent that these funds are used for capital purposes, modernization or construction to meet the demands of changing technology and needs, such efforts would grind to a sudden halt. Where these funds are used to meet operating costs, the costs of education, research or the application of new technology, such programs would also be dangerously impaired.

According to 1970 IRS statistics, of the 35.5 million taxpayers who itemized deductions, 29 million deducted 3 percent or less for charitable contributions. These deductions totaled $10.56 billion, or 82 percent of all itemized and individually contributed dollars. Thus, 29 million out of 35.5 million taxpayers would have no income tax

incentive for their contributions if, as has been suggested, a 3 percent floor provision were to be enacted. Such a provision, we believe, would be a disincentive for taxpayer contributions, requiring that other sources fill the breach.

One proposal would disallow the charitable contribution as a deduction in determining the taxable income, but would allow every taxpayer a tax credit of 24 percent of a contribution. For the taxpayer in an income bracket with a tax liability in excess of this tax level, the proposal would certainly discourage contributions. The effect on the generous impulses of the taxpayer in the higher bracket would be the same as the three percent floor. And since the net economic cost to him would be greater, fewer dollars would be contributed.

Another concept for change would place a ceiling of 50 percent on a charitable contribution which could be deducted for the purposes of computing the Federal estate tax. Under the present law, the charitable deduction for estate tax purposes is without restriction. Referring again to our survey of 3,530 voluntary nonprofit community hospitals, the responding institutions reported that some $45 million came through bequests from testators. If a 50 percent ceiling had been in effect at the time these wills were drawn, there can be little question that the $45 million would have been substantially less. Therefore, this concept, like the foregoing proposal, could only add to the financial burdens of the government and the paying patients.

In this connection I would like to call to the attention of the Committee the conclusion reached by the American Law Institute, that:

> "The 100 percent charitable deduction in the field of transfer taxation should be retained, under either a dual tax system or a unified tax."

To impose a gift tax on a transfer to charity would be to discourage giving to charity which is directly contrary to the long-standing policy of Congress to encourage contributions through the income and estate tax deduction.

A proposal which has been made in times past and no doubt will again be considered would be to change the rules with respect to the deductibility of gifts of appreciated property. This type of gift is of prime importance to many charities and is of significant interest to the hospital field. Again referring to the survey which the Association made recently, the 891 responding hospitals reported non-cash gifts totaling almost $26 million. It is safe to say that in many instances non-cash gifts represented gifts of appreciated property. While it is not always possible to know the tax status of the donor from the records of an institution, we certainly may assume that a gift made other than cash serves a purpose of the donor. Most likely that purpose would be the added tax incentive which he receives as a result of the appreciation in the property donated. Thus, a change in provisions with respect to the deductibility of gifts of appreciated property, just as would be true for the two examples I've already cited, would only result in another disincentive to charitable contributions. And on this basis such a proposal would be opposed by hospitals. Moreover, we believe that *any* deterrent to charitable giving would be contrary to the public interest and detrimental to the capability of voluntary nonprofit hospitals to provide public service.

Hospitals provide an indispensable public service. This service has become more imperative with the recognition that health care is an inherent right of all persons. Demands on hospitals, as a result, can only continue to increase as we strive to make their services more accessible to everyone in a growing population. Our hospital system—by public preference—continues to be financed

through multiple sources and includes varied forms of delivery of health services. But voluntary nonprofit hospitals predominate. These nonprofit institutions must rely on numerous sources of financing, many of which fail to meet the totality of costs. Thus, a vital component of nonprofit hospital financing continues to come through the charitable contributions of concerned citizens.

Any decrease in voluntary gifts will force such hospitals to increase their charges to all patients and the government for its beneficiaries in programs such as Medicare and Medicaid. And it is our feeling that any such increase in charges will in many instances result in a limitation on service to the public by placing hospital care beyond the financial reach of many persons. This is why we request that your Committee support provisions that would strengthen rather than inhibit incentives for voluntary gifts. Such contributions are essential to community service.

Mr. Chairman, we appreciate the opportunity to present the views of the hospital field to the Committee and would be pleased to answer any questions which the Committee members may have.

[Emblem]

AFFIDAVIT

The information indicated below applies to fiscal year July 1, 1972, through June 30, 1973.

Number of indigent patients treated free or part pay in the Emergency Department:	32
Number of indigent in-patient admissions with care on a free or part pay basis:	68
Total number of patients, including the indigent, Emergency Department:	12,098
Total number of in-patient admissions, including the indigent:	6,767

Noted:

The records as pertains to the number of indigent, free and part pay cases, were commenced in November, 1972; theretofore, no statistics were maintained on these patients.

The number of indigent, free and part pay cases, treated during the period of this report may increase as circumstances become known and occasion reclassification.

/s/ Paul A. Bjork
PAUL A. BJORK
Executive Director

Sworn to and Subscribed before me
this 17 day of July 1973

/s/ Charles E. McHale, Jr.
Notary Public

METHODIST HOSPITAL

5620 Read Road—New Orleans, Louisiana 70127
Telephone (504) 241-2400

Office of the Administrator

W. E. Elliott, President
Board of Directors

THE METHODIST HOSPITAL OF KENTUCKY

INCORPORATED

Pikeville, Kentucky

ALL AMERICA CITY

July 13, 1973

Office of Chief Counsel
General Litigation Division
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, D.C. 20224

Personal Attention of: John B. Cummings
Room 4242

I, Lee D. Keene, Administrator of the Pikeville Methodist Hospital, do hereby certify that the following information is true and correct to the best of my knowledge and belief.

1. Unable to provide specific information concerning the number of patients treated by the hospital for free in the emergency room.
2. Unable to provide specific information concerning the number of patients treated by the hospital on a reduced charge basis in the emergency room.
3. Twenty-four (24) patients were treated by the hospital for free on a regular admission basis.
4. 2,310 patients (1,542 Medicare—768 Medicaid) were treated by the hospital on a reduced charge basis on a regular admission basis.
5. 15,386 patients were treated by the hospital in the emergency room.

6. 8,110 patients were treated on a regular admission basis.

The above information is furnished for the fiscal year ended September 30, 1972.

/s/ Lee D. Keene
LEE D. KEENE
Administrator

Subscribed and sworn to before me by Lee D. Keene, this 13th day of July 1973.

/s/ [Illegible]
Notary Public
Kentucky State at Large

My commission expires 4-15-74

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil No. 1378-71

[Filed Feb. 22, 1974]

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,
Plaintiffs

v.

GEORGE P. SHULTZ, ET AL.,
Defendants

NOTICE OF APPEAL

Notice is hereby given that the defendants hereby appeal to the United States Court of Appeals for the District of Columbia Circuit from the order and judgment entered in this action on January 29, 1974, granting plaintiffs' motion for summary judgment, and denying defendants' motion for summary judgment, and issuing an injunction against defendants.

Respectfully submitted,

February 22, 1974

/s/ John J. McCarthy
JOHN J. MCCARTHY
DONALD J. GAVIN
MILAN D. KARLAN
Attorneys
Tax Division
Department of Justice
Washington, D. C. 20530

Of counsel:

HAROLD H. TITUS, JR.,
United States Attorney

CERTIFICATE OF SERVICE

It is hereby certified that service of this appendix for the appellants has been made on the appellees, by and through their counsel of record, by mailing four copies thereof on this —— day of April, 1974, in an envelope, with postage prepaid, properly addressed to him as follows:

Irving Weiser, Esquire
c/o Biltmore Hotel
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Los Angeles, California 90013

SCOTT P. CRAMPTON
Assistant Attorney General

GENERAL DOCKET

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

74-1293

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.

v.

WILLIAM E. SIMON, ET AL., Secretary of Treasury,
Appellants

APPEAL FROM THE DISTRICT COURT

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Pro Hac Vice:

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American Hospital Assoc., movant for leave to file brief as amicus curiae:

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Attorneys for Appellee

Marilyn G. Rose, 872-0670
1751 N Street, N.W., 20036

No. below: Civil Action 1378-71

Judge below: Barrington D. Parker

Date of Judgment: January 29, 1974

Notice of appeal filed: February 22, 1974

DATE	FILINGS—PROCEEDINGS
(L)2-26-74	Certified Original Preliminary Record (no transcript)
(G)2-26-74	4-Appellants' motion for stay of injunctive relief (m-26)
(G)3-6-74	4-Appellees' opposition to motion for stay (m-6)
(G)3-6-74	4-Motion of American Hospital Association for leave to file brief as amicus curiae, participate in oral argument and to file memorandum in support of stay (m-6)
(G)3-11-74	4-Appellants' reply to opposition to motion for stay (m-11)
(G)3-12-74	4-Appellees' response to motion by American Hospital Association for leave to file brief as amicus curiae and to participate in oral argument (m-11)
(G)3-14-74	4-Appellees' reply to opposition to motion to stay (m-14)
(G)3-14-74	4-Appellants' supplemental memorandum in support of motion for stay (m-14)
(M)3-21-74	4-Request for expedited consideration of Appellants' motion for stay (m-21)
(M)3-26-74	Per Curiam order granting the motion for leave to file brief as amicus curiae; the motion to participate in oral argument is denied without prejudice to its renewal before

DATE	FILINGS—PROCEEDINGS
(M)3-26-74	the division of the Court assigned to hear this case on the merits; the Clerk is directed to file the memorandum in support of stay of amicus curiae; the motion for stay is denied; the parties to this appeal are directed to submit to the Court, by April 10th, an expedited briefing schedule which provides for the filing of final briefs no later than May 6, 1974; the Clerk is directed to schedule this case for argument during the May/June sitting period of the Court; Fahy, Sr. CJ and Robinson, CJ
(M)3-26-74	4-Memorandum of American Hospital Asso. in support of motion for stay
(G)4-1-74	4-Appellees' motion for leave to file joint briefing schedule seeking additional time to file briefs (m-1)
(G)4-2-74	Certified Original Record 2 volumes (no transcript) (n) 5-16
(B)4-5-74	Clerk's order directing Clerk to file joint motion for briefing schedule and further ordered that the following schedule shall apply: Appellant's brief—April 17th; Appellees' brief—May 13th; Reply brief, if any,—May 17th
(B)4-5-74	4-Joint briefing schedule of parties (m-1)
(G)4-17-74	25-Brief of American Hospital Association as amicus curiae (p.17)
(G)4-17-74	4-Appellants' motion for leave to file opening brief which exceeds the length allowed by Rule 28(g) of the FRAP and temporarily to file typewritten copies of the brief (OK HK) .(m-17)
(I)4-19-74	10-Joint Appendix, (m-17)

DATE	FILINGS—PROCEEDINGS
(B)5-7-74	Clerk's order directing Clerk to file appellant's brief in excess of page limitation
(B)5-7-74	7-Appellant's typewritten brief (m-17)
(B)5-7-74	25-Appellant's printed brief (m-29)
(B)5-8-74	Clerk's order sua sponte, that the following times will be allotted for oral argument in this matter: Appellants—20 minutes Appellees—20 minutes
(L)5-13-74	4-Appellees' motion for leave to file temporarily typewritten copies of brief (p-13)
(M)5-14-74	Clerk's order granting appellees' motion for leave to file temporarily typewritten copies of the brief
(M)5-14-74	7-Appellees' brief (p-13)
(B)5-15-74	4-Motion of amicus curiae American Hospital Assoc., for leave to participate in oral argument (m-14)
(G)5-16-74	4-Appellees' opposition to motion by The American Hospital Association to participate in oral argument (m-16)
(G)5-17-74	25-Appellees' brief (m-17)
(M)5-21-74	Clerk's order denying motion of amicus curiae American Hospital Asso. for leave to participate in oral argument
(G)5-21-74	Letter from appellants advising of additional authorities pursuant to local Rule 8(g)
(G)5-21-74	4-Appellants' motion to substitute party (m-17)
(G)5-21-74	25-Appellants' reply brief (m-17)

DATE	FILINGS—PROCEEDINGS
(M)5-22-74	Clerk's order granting appellants' motion to substitute party and the Clerk is directed to remove the name of George P. Shultz as an appellant and to substitute therefor the name of William E. Simon
(G)5-28-74	4-Appellees' motion for leave to file supplemental brief (m-28)
(B)5-31-74	Clerk's order granting appellees' motion for leave to file a supplemental brief and Clerk is directed to file aforesaid brief
(G)5-31-74	15-Appellees' supplemental brief (m-28)
(M)6-12-74	Argued before Wright and Wilkey, CJ and William J. Jameson, U.S. Sr. District Judge for the District of Montana, sitting by designation; On motion by Leonard J. Henzke, Jr., Wesley J. Filer a member of the bar for the Supreme Court of Texas was allowed to argue pro hac vive for appellant's
(B)7-8-74	1-Letter from counsel for appellant informing Clerk of additional authorities pursuant to Local Rule 8 (g)
10-9-74	Opinion for the Court filed by Senior District Judge Jameson.
10-9-74	Opinion concurring in part and dissenting in part filed by Circuit Judge Wright.
10-9-74	Judgment reversing judgment of the District Court. (n)
(G)10-15-74	1-Appellants' Bill of Costs (m-11)
(G)10-23-74	25-Appellees' petition for rehearing and/or suggestion for rehearing en banc (m-23)
12-6-74	Per Curiam order denying appellees petition for rehearing.

DATE	FILINGS—PROCEEDINGS
12-6-74	Circuit Judge Wright would grant rehearing for the reasons set forth in his statement as to why he voted to grant rehearing en banc.
12-6-74	Per Curiam order denying suggestion for rehearing en banc.
12-6-74	Statement of Chief Judge Bazelon with whom Circuit Judges Wright and Robinson concur, as to why he voted to grant rehearing en banc.
12-6-74	Statement of Circuit Judge Wright, with whom Chief Judge Bazelon and Circuit Judge Robinson concur as to why he voted to grant rehearing en banc.
12-17-74	Copy of opinion of 10-9-74 and 12-6-74 on rehearing and certified copy of judgment and bill of costs in the amount of $279.35 issued to the District Court.
(B)2-26-75	4-Appellees' motion for transmittal of certified original record to the Supreme Court (m-2-)
(B)3-7-75	Notification of filing a petition for certiorari in the Supreme Court on March 6, 1975 in no. 74-1110
(R)3-11-75	Order per CJ Bazelon granting motion for transmittal of certified record to the Supreme Court
(G)3-12-75	Notification of filing a petition for certiorari in the Supreme Court on March 8, 1975 in No. 74-1124
(P)4-1-75	Certified record of pleadings, etc. prepared and hand delivered to Supreme Court.

DATE	FILINGS—PROCEEDINGS
(R)4-1-75	Certified copy of the order of 3-11-75 and the Certified Preliminary Record and the Certified Original Record 2 vol. sent to Clerk, U.S. Supreme Court
(R)4-1-75	Receipt returned from Clerk, U.S. Supreme Court for Certified Preliminary Record and the Certified Original Record 2 vols.
(C)5-27-75	Certified copy of order from Supreme Court granting petitions for writs of certiorari in Nos. 74-1110 & 74-1124.

SUPREME COURT OF THE UNITED STATES

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,
Petitioners

v.

WILLIAM E. SIMON, Secretary of the Treasury, ET AL.

ORDER ALLOWING CERTIORARI

Filed May 19, 1975

The petition herein for a writ of certiorari to the United States Court of Appeals for the District of Columbia Circuit is granted. This case is consolidated with No. 74-1124 and a total of one hour is allotted for oral argument.

SUPREME COURT OF THE UNITED STATES

No. 74-1124

WILLIAM E. SIMON, Secretary of the Treasury, ET AL.,
Petitioners

v.

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.

ORDER ALLOWING CERTIORARI

Filed May 19, 1975

The petition herein for a writ of certiorari to the United States Court of Appeals for the District of Columbia Circuit is granted. This case is consolidated with No. 74-1110 and a total of one hour is allotted for oral argument.

Supreme Court, U. S.
FILED
MAY 2 1975

No. 74-1110

In the Supreme Court of the United States

OCTOBER TERM, 1974

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL., PETITIONERS

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

ROBERT H. BORK,
Solicitor General,
Department of Justice,
Washington, D.C. 20530.

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In the Supreme Court of the United States

OCTOBER TERM, 1974

NO. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL., PETITIONERS

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The opinion of the district court (Pet. App. D 33a-57a) is reported at 370 F. Supp. 325. The opinion of the court of appeals (Pet. App. C 7a-32a) is reported at 506 F.2d 1278.

JURISDICTION

The judgment of the court of appeals was entered on October 9, 1974. On December 6, 1974, the court denied Eastern Kentucky's petition for rehearing and also denied its suggestion for rehearing *en banc* (Pet. App. A 1a-5a; App. B 6a). The petition for a writ of certiorari was filed on March 6, 1975. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

QUESTIONS PRESENTED

1. Whether a revenue ruling issued by the Secretary of the Treasury providing that a hospital is entitled to exemption from taxes if it furnishes emergency care for all patients regardless of their ability to pay correctly interprets Section 501(c)(3) of the Internal Revenue Code of 1954, which accords tax-exempt status to organizations organized and operated exclusively for "charitable" purposes.

2. Whether the Secretary's promulgation of the revenue ruling was exempt from the notice and hearing requirements of the Administrative Procedure Act because the ruling was an "interpretative rule."

STATUTES AND REGULATIONS INVOLVED

The relevant provisions of the Internal Revenue Code and the Treasury Regulations are set forth in Appendix G of the petition.

STATEMENT

This class action was brought by several individuals and a number of national and regional nonprofit health and welfare organizations on behalf of all indigent persons who are unable to pay for the costs of hospital care. The complaint alleged that the Secretary of the Treasury and the Commissioner of Internal Revenue erroneously recognized as tax-exempt under Section 501(c)(3) of the Internal Revenue Code of 1954, private nonprofit hospitals that do not render free or below-cost medical service to indigents. Petitioners sought broad declaratory and injunctive relief which would require the Treasury to deny such hospitals tax-exempt status under Section 501(c)(3) of the Internal Revenue

Code of 1954 and bar deductibility of contributions to them under Section 170(c)(2) (J.A. 25-28).[1]

The circumstances which gave rise to this action concern the promulgation of two revenue rulings setting forth the Internal Revenue Service's position with regard to the exempt status of nonprofit hospitals.[2] The first of the two rulings, Revenue Ruling 56-185, 1956-1 Cum. Bull. 202, enumerated four general requirements which a hospital was required to satisfy to establish that it was exempt as a public charitable organization within the contemplation of Section 501(c)(3). One of the requirements included the condition that, to the extent of its financial ability, the hospital serve those not able to pay for the services rendered.

The Commissioner issued a second revenue ruling in 1969 modifying the earlier ruling. The later ruling, Revenue Ruling 69-545, 1969-2 Cum. Bull. 117, provided that a nonprofit hospital would also qualify for tax-exempt status if it operated a full-time emergency room which was open to all patients, regardless of their ability to pay, and if it accepted all patients who could pay the costs of their regular hospital care either directly or through some form of third-party reimbursement program, such as private health insurance, Medicare or Medicaid. Revenue Ruling 69-545 further stated that such a hospital would be recognized as tax-exempt even though non-emergency patients who could not meet the financial requirements for admission were ordinarily referred to another hospital in the community that did serve indigent patients.

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[1] "J.A." refers to the joint appendix filed in the court of appeals.

[2] Such rulings are published communications of the Commissioner of Internal Revenue to field offices, taxpayers, taxpayers' representatives, trade associations and others. The stated purpose of the revenue rulings system is to inform subordinate revenue officials of established policies and to make such information available to the public. Rev. Rul. 2, 1953-1 Cum. Bull. 484; Rev. Rul. 212, 1953-2 Cum. Bull. 449. See also *Dixon* v. *United States*, 381 U.S. 68, 73.

In this action, petitioners alleged that Revenue Ruling 69-545 was an erroneous interpretation of Section 501(c)(3) and that the Commissioner's issuance of the ruling had resulted in their inability to receive medical care from tax-exempt hospitals. They further alleged that the ruling was void since it had not been issued in accordance with the rule-making provisions of the Administrative Procedure Act requiring a public hearing and an opportunity for interested and affected persons to be heard. Petitioners sought a judicial declaration that the Treasury officials had acted unlawfully in recognizing the tax-exempt status of private nonprofit hospitals that did not admit indigents and provide free or below-cost medical care to them. Petitioners also sought an injunction requiring the Commissioner of Internal Revenue to revoke the exempt status of hospitals that did not furnish free care and to prohibit the future recognition of such hospitals as exempt organizations under Section 501(c)(3) (J.A. 25-28).

The Treasury officials moved to dismiss the complaint on the ground that the court lacked jurisdiction. The district court denied the motion to dismiss without opinion (J.A. 32). Subsequently, upon the parties' cross motions for summary judgment, the district court granted summary judgment for petitioners. It held that the court had jurisdiction to determine whether Revenue Ruling 69-545 was erroneous and that petitioners had standing to maintain the action. The court further held that the revenue ruling at issue was invalid. In view of that holding, the court did not reach the issue whether the ruling was void because it was not issued in accordance with the notice and hearing provisions of the Administrative Procedure Act (Pet. App. D 33a-57a). The district court entered a declaratory judgment and an injunction along the lines sought by petitioners.

The court of appeals reversed. It held that Revenue Ruling 69-545 was not inconsistent with the legislative intent of Section 501(c)(3) and that the modification of the prior revenue ruling was proper. That court also concluded that the revenue ruling was interpretative, and thus not subject to the notice and hearing provisions of the Administrative Procedure Act, and that promulgation of the ruling did not constitute an abuse of discretion (Pet. App. C 7a-32a).[3]

ARGUMENT

1. In contending (Pet. 13-15) that Revenue Ruling 69-545 misinterprets the "charitable" requirement of Section 501(c)(3) of the Code, petitioners seek a judicial pronouncement requiring a change in the current social policies governing the extent to which hospitals furnish medical care for the indigent. Revenue Ruling 69-545 provides that a nonprofit hospital will qualify for tax-exempt status if it operates a full-time emergency room which is open to all patients, regardless of their ability to pay, and if it accepts all patients who can pay the costs of their regular hospital care either directly or through some form of third-party reimbursement.

The ruling accords with the statutory definition of the term "charitable." As the court of appeals correctly noted (Pet. App. C 20a-25a), it is well established that the term "charitable" may be defined more broadly than merely relief of the poor. Although the Treasury Regulations under the 1939 Code predecessor provision of Sec-

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[3]Although the court of appeals reversed the district court on the merits, it sustained its holding with respect to jurisdiction. The court of appeals concluded that the defenses of standing, sovereign immunity, the Anti-Injunction Act, or the Declaratory Judgment Act were not applicable. It thereby concluded that the district court had jurisdiction to grant the relief requested (Pet. App. C 12a-18a). Because of this jurisidictional holding of the court of appeals, we have filed a conditional cross-petition (No. 74-1124) on behalf of the Secretary of the Treasury. That petition seeks review by this Court only in the event it grants the petition in this case.

tion 501(c)(3) had specified "relief for the poor" as the applicable charitable requirement,[4] the current Regulations,[5] which were adopted after hearing, provide that the term "charitable" must be used in its generally accepted legal sense, which is not limited to its popular sense of benevolence to the poor. *Green* v. *Connally,* 330 F. Supp. 1150, 1159 (D. D.C.), affirmed *per curiam sub nom. Coit* v. *Green,* 404 U.S. 997. Thus, for example, the law of trusts has adopted a broader definition to include the promotion of health as a charitable purpose. See, *e.g.,* Restatement 2d, Trusts, Sec. 368, p. 246 (1959 ed.); IV Scott, *Trusts,* Sec. 368, p. 2853 (3d ed., 1967); *Brattleboro Retreat* v. *Town of Brattleboro,* 106 Vt. 228, 173 Atl. 209; *Evangelical Lutheran Good Samaritan Society* v. *County of Gage,* 181 Neb. 831, 151 N.W. 2d 446; *City of Richmond* v. *Richmond Memorial Hospital,* 202 Va. 86, 94, 116 S.E. 2d 79, 84. See also *Jackson County, Missouri* v. *State Tax Commission,* No. 58676 (Mo. Sup. Ct.), decided March 10, 1975 (*en banc*), holding that a hospital qualified as charitable for state tax purposes even though it had no program for furnishing free non-emergency medical care to indigents.

In light of the foregoing evolution of the term "charitable," the Treasury's modification of its position with respect to the tax-exempt status of hospitals is reasonable. Contrary to petitioners' argument, the Treasury is not required to ignore the general legal definition of "charitable" and employ an interpretation which, in petitioners' view, would result in greater bene-

[4]However, as early as 1924, the Treasury had employed the broader definition of "charitable" which was finally incorporated in the Regulations under the 1954 Code. See Sol. Op. 159, III-1 Cum. Bull. 480; compare S.M. 2160, III-2 Cum. Bull. 151, with I.T. 1800, II-2 Cum. Bull. 152.

[5]See Treasury Regulations, Section 1.501(c)(3)-1(d)(2), issued as T.D. 6391, 24 Fed. Reg. 5217, 5219.

fits to indigent persons. Whatever its prior regulations may have provided, the Treasury is empowered to alter its legal position as set forth in published revenue rulings. See, *e.g., Dixon* v. *United States,* 381 U.S. 68; *Automobile Club* v. *Commissioner,* 353 U.S. 180, 184. Indeed, this case would follow *a fortiori* from the decisions of this Court holding that even Treasury Regulations approved by Congress may be changed pursuant to the broad power of the Secretary under Section 7805 (a) of the Code. See, *e.g., Helvering* v. *Reynolds,* 313 U.S. 428, 432; *Helvering* v. *Wilshire Oil Co.,* 308 U.S. 90, 101; *Morrissey* v. *Commissioner,* 296 U.S. 344.[6]

Finally, petitioners contend (Pet. 15-18) that the Treasury's hospital exemption policy must follow other federal policies with respect to health insurance and hospital grant legislation. However, the tax exemption policies established by Congress are designed to encourage a broad pluralism of activities aimed at furthering the public good, as long as the activities meet minimum charitable trust standards[7] and do not contravene any express public policy. By contrast, federal programs involving direct grants, such as for hospital construction, must be subject to far stricter guidelines and controls. Revenue

[6]Apart from the fact that the cases relied upon by petitioners (Pet. 13-14) were decided under the Regulations of the 1939 Code, none of them involved a situation comparable to that presented in Revenue Ruling 69-545. In each of those cases, income of the hospitals inured to private individuals and no hospital provided free emergency care to indigents.

[7]Petitioners rely (Pet. 10-11) on cases such as *Citizens to Preserve Overton Park* v. *Volpe,* 401 U.S. 402, to show that the Treasury improperly ignored the needs of the poor in issuing Revenue Ruling 69-545. But those cases involved statutes which expressly required formal plans or studies by the agency as a prerequisite to action. Although we are advised by the Internal Revenue Service that it undertook extensive studies and consultation with other agencies respecting hospital care for indigents prior to issuing Revenue Ruling 69-545, such formal procedures are not required by the Internal Revenue Code. At all events, the revenue ruling itself indicates that the interests of the poor were considered in establishing the standard requiring emergency care for indigents.

Ruling 56-185, which granted tax-exempt status to a hospital which provided free care for all indigents, set forth one means of benefiting the community; Revenue Ruling 69-545, which granted tax-exempt status to a hospital which furnished emergency care for all and non-emergency care for all with third-party reimbursement, recognized another type of community benefit program. There may well be other hospital programs which would satisfy the charitable trust standard. Under the present Section 501(c)(3) provisions, such variant approaches to community benefit are equally sufficient to meet what must be an essentially flexible statutory standard.

2. Petitioners further argue (Pet. 8-10) that Revenue Ruling 69-545 is invalid because the Treasury did not promulgate it in accordance with the notice and hearing requirements of the Administrative Procedure Act (5 U.S.C. 553). But these provisions, as the court of appeals correctly held (Pet. App. C 28a-29a), do not apply to revenue rulings because they come within the exception for interpretative rules in 5 U.S.C. 553. It is well settled that agency rulings that do not bind the affected parties or the courts are considered to be interpretative. See, *e.g., American President Lines, Ltd.* v. *Federal Maritime Commission,* 316 F.2d 419, 422 (C.A. D.C.); *Gibson Wine Co.* v. *Snyder,* 194 F.2d 329, 331-332 (C.A. D.C.); *Stevens Elec. Paste Co.* v. *Environmental Protection Agency,* 461 F.2d 293, 304 (C.A. 7).

Unlike the cases relied upon by petitioners, which involve substantive agency orders with binding legal effect,[8] revenue rulings merely represent the views of the Internal

[8]See, *e.g., National Labor Relations Board* v. *Wyman-Gordon Co.,* 394 U.S. 759; *Lewis-Mota* v. *Secretary of Labor,* 469 F.2d 478 (C.A. 2); *Texaco, Inc.* v. *Federal Power Commission,* 412 F.2d 740 (C.A. 3).

Revenue Service as to the proper interpretation of the statute. As this Court stated in *Dixon* v. *United States, supra,* 381 U.S. at 73, revenue rulings are "merely guidelines for * * * [Internal Revenue Service] personnel." Originally, such rulings were sent by high Treasury officials as "circulars" containing administrative instructions to lower revenue officials.[9] Later, synopses of such rulings were published (see Synopsis of Sundry Treasury Decisions (1869)), and occasionally opinions of the Attorney General on revenue matters were included in such compilations (see T.D. 3570, III-1 Cum. Bull. 85 (1924), considered in *Squire* v. *Capoeman,* 351 U.S. 1, 8-9).[10]

In 1953, the revenue rulings program was reorganized in order to supersede and coordinate the large number of types of instructions and opinions which were then issued or published by diverse offices of the Bureau of Internal Revenue, such as General Counsel's Memoranda (G.C.M.) and Solicitor's Opinions (Sol. Op.). At that time, it was stated that the purpose of the revenue rulings program was to inform subordinate officials of established policies and to make such information available to the public. Rev. Rul. 2, 1953-1 Cum. Bull. 484; Rev. Rul. 212, 1953-2 Cum. Bull. 449. Thus, the courts have consistently held that revenue rulings are merely legal opinions issued by the Commissioner's staff which have no binding force or effect of law and are subject to repeated retroactive revocation or change.

[9]The first such "circular" was sent by Secretary of the Treasury Alexander Hamilton to collectors, and dealt with the proper leakage allowance for purposes of the taxes on distilled spirits and molasses. It is reprinted in *Work and Jurisdiction of the Bureau of Internal Revenue,* G.P.O. (1948), p. 9.

[10]Opinions of the Attorney General which were not given Treasury Decision numbers, but which served the same function as tax rulings, include 39 Ops. A.G. 261-266 (1939); 25 Ops. A.G. 605-607 (1906); 24 Ops. A.G. 1-8 (1902); 1 Ops. A.G. 345-346 (1820); 1 Ops. A.G. 269- 270 (1819).

See, *e.g.*, *Bartels* v. *Birmingham*, 332 U.S. 126, 131-132; *Automobile Club* v. *Commissioner*, *supra*, 353 U.S. at 184; *Sims* v. *United States*, 252 F. 2d 434, 438 (C.A. 4); *United States* v. *Bennett*, 186 F.2d 407, 410 (C.A. 5); *United States* v. *Hall*, 398 F.2d 383, 387 (C.A. 8). They are therefore within the exception in 5 U.S.C. 553 to the notice and hearing requirements for "interpretative rules."

CONCLUSION

For the reasons stated, it is respectfully submitted that the petition for a writ of certiorari should be denied.

ROBERT H. BORK,
Solicitor General.

MAY 1975.

Supreme Court, U. S.
FILED
JUL 18 1975
MICHAEL RODAK, JR., CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1975

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,
Petitioners
v.
WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,
Respondents

No. 74-1124

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,
Petitioners
v.
EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,
Respondents

On Certiorari to the United States Court of Appeals for the District of Columbia Circuit

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BRIEF FOR THE PETITIONERS IN NO. 74-1110

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In the Supreme Court of the United States

OCTOBER TERM, 1975

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,
Petitioners

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,
Respondents

No. 74-1124

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,
Petitioners

v.

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,
Respondents

On Certiorari to the United States Court of Appeals for the District of Columbia Circuit

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BRIEF FOR THE PETITIONERS IN NO. 74-1110 [1]

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[1] This Court granted cross-petitions for writs of certiorari and ordered the consolidation of the cases. The parties have agreed that Plaintiffs (petitioners in No. 74-1110 and respondents in No.

OPINIONS BELOW

The opinion of the Court of Appeals (Pl. Pet., pp. 7a-32a)[2] is reported at 506 F.2d 1278. The memorandum opinion of the District Court (Pl. Pet., pp. 33a-57a) is reported, *sub nom. Eastern Kentucky Welfare Rights Organization, et al.* v. *Shultz, et al.*, at 370 F.Supp. 325. An additional memorandum order (Pl. Pet., pp. 58a-60a) and the Judgment (Pl. Pet. pp. 61a-63a) are unreported.

JURISDICTION

The judgment of a divided Court of Appeals for the District of Columbia Circuit, reversing the District Court, was entered on October 9, 1974. A timely petition for rehearing was denied, with dissent (Pl. Pet., 6a), as was the suggestion for rehearing *en banc*, with three dissents, on December 6, 1974 (Pl. Pet., pp. 1a-5a). On application filed by the Solicitor General, the Chief Justice extended the time for filing a petition for a writ of certiorari to and including March 8, 1975. Plaintiffs' petition was filed on March 6, 1975. Defendants' petition was filed on March 8, 1975. Both petitions were granted and the cases consolidated on May 19, 1975. The jurisdiction of this Court rests on 28 U.S.C. § 1254 (1).

QUESTIONS PRESENTED

(1) Whether defendants have violated the Internal Revenue Code by the issuance of a ruling eliminating the long-standing requirement that non-profit hospitals

74-1124) in a single opening brief would address the issues raised by both writs, and the opposing parties would each file single responsive briefs also addressing the issues raised by both writs. For convenience, hereinafter petitioners in 74-1110 will be called "plaintiffs" and petitioners in 74-1124 will be called "defendants".

[2] Citations to "Pl. Pet." refer to the appendix to plaintiffs' petition.

accept patients unable to pay as a condition for retaining the status and benefits accorded to "charitable" institutions under the Internal Revenue Code (26 U.S.C. §§ 501 (c) (3) and 170(a)-(c));

(2) Whether defendants, in issuing rules which have a substantial impact upon an industry and a large segment of the public, and which alter the long-standing legal obligation of that industry to that segment of the public, must follow the rule-making requirements of the Administrative Procedure Act (5 U.S.C. § 553);

(3) Whether defendants could issue a ruling which eliminates the legal obligation of "charitable" tax exempt hospitals to accept patients unable to pay without considering all relevant factors, including the impact upon the ability of millions of poor persons to obtain hospital services, and the policies and views of Congress and the health agency of the United States which continue to require that nonprofit hospitals serve the indigent;

(4) Whether the federal courts lack jurisdiction to consider the above issues by reason of the limitations in the anti-injunction provisions of the Internal Revenue Code (26 U.S.C. § 7421(a)), the tax exception to the Declaratory Judgment Act (28 U.S.C. §§ 2201-2202), and the doctrine of sovereign immunity.

STATUTES AND REGULATION INVOLVED

The pertinent provisions of the Internal Revenue Code (26 U.S.C. §§ 501(c)(3), 170(a)-(c), and 7421), the Administrative Procedure Act (5 U.S.C. 553 and 706(2)(A)), the Declaratory Judgment Act (28 U.S.C. § 2201), and the pertinent provisions of the treasury regulation (26 CFR 1.501) are set forth in an appendix to this brief, *infra*, pp. 1a-5a.

STATEMENT OF THE CASE

I. FACTS

The Internal Revenue Code (hereinafter "the Code"), since its inception, has provided tax exemption for the income of, and subsequent amendments have permitted donors to deduct contributions to, certain organizations categorized as "charitable". (See current provisions, 26 U.S.C. §§ 501(c)(3) and 170(a)-(c), *infra*, pp. 1a-2a). Other organizations categorized as "educational" and "religious" have always been accorded the same benefits as "charitable" organizations, and "scientific" and "literary" organizations and societies for the prevention of cruelty to children and animals subsequently have been granted similar treatment by Congress. On the other hand, nonprofit hospitals and other nonprofit health institutions have never been granted the same independent special tax status under the Code but have only qualified for such tax benefits if they fit into the "charitable" category. On two occasions amendments were proposed in Congress which would have accorded health institutions (in 1924) and hospitals (in 1969) favorable tax status independent of the "charitable" category, but on both occasions the attempt failed.

Prior to October 8, 1969, the long-standing policy of the Internal Revenue Service (hereinafter "IRS") required that a nonprofit hospital in order to be qualified as charitable under the Code,

> ". . . be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay . . . [and]
>
> . . . not refuse to accept patients in need of hospital care who cannot pay for such services. . . ." Rev. Rul. 56-185, 1956-1 Cum. Bull. 202.[3]

[3] Revenue Ruling 56-185 is set forth in full *infra*, pp. 6a-10a.

While recognizing that nonprofit hospitals must charge those able to pay for service in order to meet the operating expenses of the institution, IRS required that "charitable" hospitals not deny medical care and treatment to others unable to pay. This policy was in accord with the legislative history of the relevant Code provisions and the long established definition of "charitable" as adopted by the federal courts.

On October 8, 1969, defendants issued a policy pronouncement (Technical Info. Rel. No. 1022), later issued as a published revenue ruling (Rev. Rul. 69-545, 1969-2 Cum. Bull. 117)[4] which removed the requirements set forth in Revenue Ruling 56-185 and prior case law that nonprofit hospitals provide care for patients without charge or at rates below cost in order to retain their "charitable" status under the Code. This new policy limited the "charitable" requirements of nonprofit hospitals to the operation of an emergency room and the provision of "hospital care to all those persons in the community able to pay the cost thereof either directly or through third party reimbursement." The ruling, on its face, is totally devoid of any consideration of the needs of indigent persons for general, non-emergency room hospital services or the number of such persons who, by virtue of the ruling, would be deprived of the ability to obtain general hospital services.

Furthermore, the ruling was issued without notice to the public and without any opportunity for the public and interested and affected persons to participate in the rulemaking process in accordance with the procedural requirements of the Administrative Procedure Act

[4] Revenue Ruling 69-545 is set forth *infra*, pp. 11a-16a.

(5 U.S.C. § 553). (App. 149-150).[5] Thereafter, several of the plaintiffs attempted to obtain a reconsideration of the ruling, but defendants rejected this attempt as "irrelevant."[6]

II. PROCEEDINGS BELOW

On July 12, 1971 plaintiffs commenced this action in the United States District Court for the District of Columbia (App. 8-30). Plaintiffs are extremely poor people and organizations representing poor people, with incomes at or below the minimal poverty guidelines and without health insurance or the resources to pay for hospital care. (App. 11-13, 17-24). Their uncontradicted affidavits recount incidents in various locations across the country since 1969 in which they and other indigent persons were denied needed hospital attention because of their inability to pay for services by nonprofit hospitals which refuse to serve persons unable to pay but still retain their status under the Code as "charitable" institutions in accordance with Revenue Ruling 69-545. (App. 78-144).

Plaintiffs alleged that the Commissioner of Internal Revenue and Secretary of the Treasury had violated

[5] Citations to "App." refer to the single appendix filed in the Supreme Court.

[6] Pursuant to a notice of hearing in the Federal Register on proposed regulations covering 26 U.S.C. § 170, the "charitable" contributions provision of the Code, (36 Fed. Reg. 9298), a number of organizations and individuals, including several of the organizational and individual plaintiffs in this case (App. 49-51), filed a statement contending that Revenue Ruling 69-545 was based on a lack of understanding of the needs of poor people for hospital services and requesting consideration of these problems in prescribing new regulations under § 170. (App. 76-77, 47-75). Counsel for the individuals and organizations appeared at the hearing held on June 28, 1971, but was told,

> ". . . that as I was present I could testify, but to be brief, as the matters which were the subject of my testimony were irrelevant to the purposes of the hearing, and that I was addressing myself to the wrong forum." (App. 77).

the Internal Revenue Code and the Administrative Procedure Act (hereinafter "APA") by the issuance of Revenue Ruling 69-545, which eliminated the requirement that nonprofit hospitals provide services to persons unable to pay in order to retain "charitable" status under the Code, and that subsequent persons serving in the same official capacities have continued those violations, thus depriving plaintiffs and other poor people of their statutory rights to obtain services from nonprofit hospitals. (App. 25-26). Plaintiffs also alleged that defendants violated the APA by failing to follow the rule-making requirements of section 553, thus denying to them their rights to participate in the rule-making process. (App. 26).

Subsequently, the district court denied defendants' Motion to Dismiss, which raised various jurisdictional barriers to the consideration of the Complaint, including the anti-injunction provision of the Code (26 U.S.C. § 7421a), the tax limitation in the Declaratory Judgment Act (28 U.S.C. 2201), the standing of plaintiffs, and the doctrine of sovereign immunity. (App. 31-33).

On cross-motions for summary judgment, the district court held that Revenue Ruling 69-545 violated the Internal Revenue Code. In reaching its decision the district court relied upon long-standing judicial and administrative authority and the legislative history which established that nonprofit hospitals must provide service to the indigent in order to retain their status as "charitable" institutions under the Code. (Pl. Pet. 46a, 48a-57a). In view of that holding, the court did not decide whether the peremptory issuance of the ruling also violated the APA (Pl. Pet. 57a). The district court also reaffirmed its position, rejecting the various jurisdictional barriers raised by defendants. (Pl. Pet. 37a-48a).

A divided panel in the court of appeals reversed the district court. While acknowledging that in the past

Congress, IRS, and the federal courts had conditioned a hospital's "charitable" status on the provision of free or below cost care to indigents, the court concluded that the determination of "charitable" status of hospitals need not always be so restricted (Pl. Pet. 23a-24a). Despite the total lack of any record that IRS considered the impact of the ruling upon poor people needing general hospital services, and a recognition by the court that IRS reached its conclusion (as set forth in the ruling) upon an analogy to trust law (Pl. Pet. 9a, n.3), the court concluded that Revenue Ruling 69-545 may be of greater benefit to the poor than the prior requirement (Pl. Pet. 27a). The court also held that the ruling was "interpretative", and therefore not subject to the rule-making requirements of section 553 of the APA. (Pl. Pet. 28a-29a). And based upon its own conjectures on the needs of the indigent, the court concluded that the ruling was not an "abuse of discretion" under Section 706(2)(A) of the APA. (Pl. Pet. 30a)

The dissenting judge stated that he would affirm the district court for the reasons stated in its opinion, and would also hold that the issuance of Revenue Ruling 69-545 worked a substantial change in the availability of hospital services to the poor without giving the poor or anyone else notice and an opportunity to comment upon it as required by section 553 of the APA. (Pl. Pet. 31a-32a). Over three dissents, review *en banc* was denied. (Pl. Pet. 1a-3a).

All three members of the court of appeals panel affirmed the judgment of the district court that it was not precluded from considering the case by virtue of the Anti-Injunction Act (26 U.S.C. § 7421a), the tax limitation clause in the Declaratory Judgment Act (28 U.S.C. § 2201), the standing of plaintiffs and the doctrine of sovereign immunity. (Pl. Pet. 12a-20a, 31a).

In their petition for certiorari plaintiffs raised the questions concerning the legality of Revenue Ruling 69-545 under sections 501(c)(3) and 170(a)-(c) of the Internal Revenue Code and sections 553 and 706(2)(A) of the Administrative Procedure Act. In their petition for certiorari defendants raised the questions concerning the jurisdiction of the district court under the anti-injunction provision of the Code (26 U.S.C. § 7421(a)), the tax limitation clause in the Declaratory Judgment Act (28 U.S.C. § 2201), and the doctrine of sovereign immunity.

SUMMARY OF ARGUMENT

I

Unlike religious and educational institutions, nonprofit hospitals have never been accorded separate status under sections 501(c)(3) and 170(c) of the Internal Revenue Code. They qualify for the tax benefits of these sections only if they can be characterized as "charitable."

For decades the IRS and the federal courts have ruled that nonprofit hospitals must provide free or below cost care to those unable to pay in order to maintain their "charitable" status. No other ruling is possible. A hospital which provides no free or below cost care is not lessening the burdens of government or otherwise providing a charitable service. It is essentially indistinguishable from the for-profit hospitals with which it is competing.

In 1969, nonprofit hospitals petitioned Congress for the same independent status under § 501(c)(3) accorded to religious and educational institutions. If the hospitals had been successful they would no longer be required to provide "charitable" service. But Congress confronted the issue squarely and squarely rejected the hospitals' petition.

Nevertheless that same year the IRS promulgated Revenue Ruling 69-545 which permits hospitals to retain their charitable status even if they afford no free care, provided they maintain an emergency room and accept public and private insurance payments. The ruling was promulgated without affording notice to and an opportunity to comment by interested persons, and nothing in the ruling indicates that the IRS considered the impact of the ruling on the health needs of poor people.

The IRS' justification for the new ruling was that it accorded with a changing view towards hospitals expressed in the law of charitable trusts. But in fact there has been no such change in the law of charitable trusts. Indeed, the very treatise sections cited by defendants are no different from what they were 30 years ago when the IRS and the courts rightly insisted that hospitals must provide free care in order to be charitable.

The court of appeals did not rely on the charitable trusts analogy but instead developed its own rationale for upholding Revenue Ruling 69-545. It thus violated one of the most basic tenets of administrative law—that a reviewing court cannot substitute its own policy justifications for the grounds relied upon by the administrative agency. Even more significantly, the court's justification for the new ruling was based on two unsupported and unsupportable premises.

First, the court suggested that the requirement that nonprofit hospitals serve those unable to pay was outdated because few people today are not covered by either public or private health insurance. But, as the Department of HEW has made clear, tens of millions of Americans are either completely without insurance coverage or have inadequate coverage.

Second, the court suggested that Revenue Ruling 69-545 might be more beneficial to the poor then the previous

requirement because it called for an open emergency room. But the court failed to address the question of where the poor are to obtain general non-emergency room hospital care. It did not face the fact that there are scores of middle-sized American communities where there is not a single public charity hospital to which the poor can turn for general hospital care, and that even where charity hospitals exist, they are often inadequate to care for all the poor.

The defendants and the court below simply ignored federal health policy. Unlike other industralized nations, the United States does not have universal health insurance. Instead, Congress has endorsed a mixed system which depends on the private sector to help provide health and hospital care to the poor. Within the last three years, for example, HEW has promulgated regulations redefining the statutory obligations of hospitals which have received Hill-Burton construction grants to serve those unable to pay. In December, 1974, Congress expressly reaffirmed these obligations. In short, Congressional policy in both the tax and health fields, judicial precedent, and the IRS' own prior rulings demonstrate that Revenue Ruling 69-545 does not comport with the Code. Defendants have no such power to amend the Code.

II

Apart from its substantive invalidity, Revenue Ruling 69-545 is procedurally invalid. The IRS promulgated it without the notice and comment period required by section 553(a) of the APA. The IRS also failed to consider the relevant health policy issues and thus abused its discretion under § 706(2)(A) of the APA.

Defendants claim that Revenue Ruling 69-545 is exempted from the requirements of section 553 as an interpretative ruling. But courts look behind the label used by agencies and require compliance with section

553 when the ruling has substantial impact on the regulated industry and the public, represents a substantial change in the law, and involves an area where the agency needs to educate itself. Revenue Ruling 69-545 affected millions of poor people and constituted a sharp break with the past. In addition, the IRS has no expertise and clearly requires education. In this regard, it is significant that HEW, which does have health expertise, complied with section 553 and even held a public hearing when it issued regulations on the obligations of Hill-Burton hospitals to provide free service to the poor.

The court below stated that Revenue Ruling 69-545 was interpretative because it was not legally binding on the courts. Yet the court went outside the record to postulate conceivable policy justifications for the ruling in the same way that a court would justify a statute challenged as irrational under the Constitution. It is difficult to see what greater binding effect the court could have given the ruling.

III

Defendants have unsuccessfully contended in the courts below that, despite the significant substantive and procedural issues raised by this case, plaintiffs have no recourse to judicial review. The defendants' position, more broadly, is that IRS tax rulings can only be challenged in court in a refund suit. This position means that IRS tax rulings which do not increase a taxpayer's burden are immune from judicial review no matter how blatantly illegal or unconstitutional they might be. The defendants' position flies in the face of the general principle that judicial review of administrative action is the rule and non-reviewability an exception which must be demonstrated by clear and convincing evidence of legislative intent. There is no such evidence here.

The Anti-Injunction Act, upon which defendants rely, bars suits for the purpose of restraining the assessment or collection of taxes. Its purpose is to prevent premature judicial interference with the collection of tax revenues. The instant case does not interfere with the collection of revenue in any way. If anything, the invalidation of the Revenue Ruling 69-545 would lead to an increase in Government revenues. The Declaratory Judgment Act bars suits "with respect to federal taxes." But legislative history and judicial precedent demonstrate that this tax suit exclusion was enacted solely to reinforce rather than expand the Anti-Injunction Act.

Defendants have also attempted to resurrect the widely criticized doctrine of sovereign immunity in this case. But this case falls within the traditional exception that sovereign immunity does not apply when an official has exceeded his statutory authority. In addition, this case was brought under the APA and, as several circuits have held, that Act constitutes a waiver of sovereign immunity.

Defendants below also contend that suits such as plaintiffs' would unduly burden the IRS and the courts. But the number of suits likely to be brought under the jurisdictional approach advanced by plaintiffs is infinitesimal compared to the massive number of refund and tax deficiency suits which the IRS and the courts now confront. Moreover, the substantive issues raised in the few non-taxpayer cases which may be brought are likely, as here, to be no different from the issues raised in refund and tax deficiency suits.

In short, defendants have not met the heavy burden they face when they argue against reviewability.

ARGUMENT

I. DEFENDANTS VIOLATED THE INTERNAL REVENUE CODE BY ELIMINATING THE OBLIGATIONS OF NONPROFIT HOSPITALS TO PROVIDE HOSPITAL CARE TO PERSONS UNABLE TO PAY AS A CONDITION FOR RETAINING "CHARITABLE" STATUS UNDER THE CODE.

A. The purpose for bestowing tax exempt and deduction benefits upon "charitable" hospitals requires that they provide service to persons unable to pay as a condition for their "charitable" status.

Unlike religious and educational institutions, nonprofit hospitals have never been accorded separate status under sections 501(c)(3) and 170(c) of the Internal Revenue Code. They qualify for the tax benefits of these sections only if they can be characterized as "charitable".[7]

The benefits accorded charitable organizations are substantial.[8] Charitable organizations are exempted from income taxes § 501(c)(3), and contributions to such organizations are deductible § 170(c). These tax benefits, which reduce the revenues of the United States, are conferred on the theory that the charitable organizations are performing functions which would otherwise need to be performed by government and are, therefore, lessening the burdens of government.[9]

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[7] The provisions originated in the first federal income tax statute in 1894. Section 32 of the Act of August 27, 1894, exempted from taxation,

> "Corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes, . . ."

The same exemptions with respect to corporation or associations organized for "religious, charitable, or educational purposes" was carried into the corporation excise tax law of 1909 (Act of Aug. 5, 1909, § 38, 36 Stat. 11) and the income tax law of 1913 (Tariff Act of Oct. 3, 1913, Ch. 16, § II(6)(a), 38 Stat. 114), which is the line progenitor of the present law. Congress has added other categories from time to time; "scientific" was added by the 1913 Act (ibid.), organizations devoted to the "prevention of cruelty to children or animals" by the 1918 Act (ibid.) (Rev. Act of Feb. 24, 1919, Ch. 18, 40 Stat. 1057, 1068), "literary" organizations by the 1921 Act (Rev. Act of Nov. 23, 1921, Ch. 136, 42 Stat. 227, 241), and organizations devoted to "public safety" with respect to 501(c)(3) status (but not 170 status) to the 1954 Act (Pub. L. 83-591, ch. 1, 68A Stat. 163). The origin of the deduction provisions appears in the 1918 Act (section 214(a)(11) Rev. Act of Nov. 23, 1921, *supra*).

[8] Without such qualification the income of nonprofit hospitals would be subject to taxation. In recent years the net income of nonprofit hospitals has considerably increased. According to reports issued by the U.S. Department of Health, Education and Welfare, based upon figures provided in the guide issues of the Journal of the American Hospital Association, nonprofit hospitals, collectively, had net income of $91,000,000 in 1961 and $457,000,000 in 1971.

See Social Security Bulletin, Vol. 36, No. 11, p. 5. U.S. Department of Health, Education and Welfare, November 1973.

Furthermore, donations of otherwise taxable income are considerable. For example, in fiscal year 1969, $2.3 billion in charitable contributions were made to hospitals, of which $1.5 billion was for construction or modernization of facilities (or 60 percent of the total $2.5 billion spent for construction that year). See Hearings on Medicare and Medicaid before the Subcomm. on Medicare-Medicaid of the Senate Comm. on Finance, 91st Cong. 2d Sess. 422 (1969).

[9] "The rationale for allowing the deduction of charitable contributions has historically been that by doing so, the government relieves itself of the burden of meeting public needs which in the absence of charitable activity would fall on the shoulders of the government." *McGlotten* v. *Connally*, 338 F.Supp. 448, 456 (D.D.C. 1972). This thesis has been set forth in a House Ways and Means Committee report which is often quoted:

> "The exemption from taxation of money or property devoted to charitable and other purposes is based upon the theory that the Government is compensated for the loss of revenue by its relief from financial burdens which would otherwise have to be met by appropriations from public funds, and by the benefits resulting from the promotion of the general welfare." H.R. Rep. No. 1860, 75th Cong., 3rd Sess. 19-20, 1938.

See also regulations defining charitable for tax exempt purposes. 26 CFR 1.501(c)-1(d)(2), *infra* pp. 3a.

It has been used by witnesses from the hospital industry in support of a continuation of the charitable deductions benefits for donors to hospitals. See testimony of representative of the Shriners Hospitals before the Ways and Means Committee:

Accordingly, nonprofit hospitals are charitable under the Code only if they lessen the burdens of government.[10] But, as many courts have concluded, hospitals which serve only those able to pay are not lessening the burdens of government; patients who can pay for health care will receive such care from the private sector.

Nonprofit hospitals which do not provide free care are no more charitable than the for-profit hospitals with which they compete.[11] Nonprofit status is not, of course, sufficient in itself to confer charitable status. There are 17 categories of nonprofit organizations under § 501(c)

"The moneys which pass to Shriners Hospitals and other public charities lessen the burden of Federal, State and local governments because of the free medical and health services we render to needy children." Committee on Ways and Means, 93rd Cong., 1st Sess., General Tax Reform, April 13, 1973, p. 6406.

See also the testimony of the President of the American Hospital Association at the same hearing, p. 6349 et seq., (See App. at 158).

[10] The Illinois Supreme Court denied tax-exempt status to an old people's home which reserved the right to discharge a resident who became sick, unmanageable, or depleted his assets, and then to cast him upon the State for care, saying,

> "The State would be bereft of any asset or estate from which it might seek reimbursement for its outlay after the person's demise. We can only infer that plaintiff's use of its property in this respect could tend to increase rather than lessen, the State's burden." *Methodist Old People's Home* v. *Korzen*, 39 Ill.2d 149, 155, 233 N.E.2d 537, 543 (1968).

In *Ruston Hospital* v. *Riser*, 191 So.2d 664 (La. 1966), the Louisiana court, noting that the institution did not admit charity patients and scheduled charges even for welfare patients, stated: "There is no basis for the contention that plaintiffs' operation in any way whatsoever served to relieve the State or its governmental subdivision of the burden of caring for the sick and indigent." See also *Presbyterian Homes* v. *Division of Tax Appeals*, 55 N.J. 275, 261 A.2d 143 (1970), and *Catholic Charities* v. *City of Pleasantville*, 109 N.J. Super. 475, 263 A.2d 803, 806 (1970). Federal cases are discussed at pp. 20-24, *infra*.

[11] In 1973 there were in the United States 3,320 nonprofit general and special hospitals, with 629,000 beds, and 757 for-profit general and special hospitals, with 63,000 beds. See American Hospital Association Guide to the Health Care Field, 1974, p. 19.

which are nontheless ineligible for the special benefits accorded to charitable organizations by § 170(c). To gain charitable status, the nonprofit hospital must do something more than merely not pay out profits to shareholders. Service to persons unable to pay is the *sine qua non* for charitable hospitals. Thus, the court below simply ignored the policy justification for according special tax benefits to donors of nonprofit hospitals when it held that defendants could relieve such hospitals of their duty to provide free or below cost care and still retain their charitable status under the Code.

The court also misread the relevant treasury regulation. It stated without analysis that the 1959 regulation (which did not follow a substantive change in the statute) broadened the concept of "charitable." (Pl. Pet. 21a). A review of that regulation indicates only that certain new types of organizations (such as civil rights groups) were now regarded as performing functions which lessen the burden of government. Nothing in the 1959 regulation suggests that organizations which systematically exclude those who cannot pay can be regarded as charitable.[12]

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[12] Nor was the court below correct in characterizing the final 1959 regulation as less restrictive than the initial 1956 proposal. (Pl. Pet. 21a). The 1956 proposal (21 Fed. Reg. 460, 464, January 21, 1956) provided:

> "Charitable organizations. Organizations formed and operated exclusively for charitable purposes include generally organizations for the relief of poverty, distress, or other conditions of similar public concern. The fact that a charitable organization established for the relief of indigent persons may receive voluntary contributions from persons intended to be relieved, or that a hospital may require payments for services from those able to pay, will not necessarily preclude exemption."

Although the term "distress" arguably may include health needs, its separate enumeration in this proposal was eliminated in the 1959 regulation, and it was linked by the conjunctive "and" to the "relief of the poor" concept. The term "other conditions of similar public concern" in the 1956 proposal is quite broad, but it was entirely

Not one of the purposes set forth in the definition of charitable in the 1959 regulation [13] describes organizations which charge all persons for service, except arguably education. However, education is specified as a *separate* exempt purpose in § 501(c)(3). Thus, educational institutions, unlike hospitals, do not have to afford "charitable" services.

General IRS policy, as expressed in other revenue rulings, confirms that "charitable" status requires donative or uncompensated undertakings. Just this past year IRS issued a comprehensive set of rulings defining when public interest law firms would be considered "charitable" for § 501(c)(3) and § 170 status. (See Revenue Rulings 75-74, 75-75, 75-76, and 75-77, March 10, 1975, Internal

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eliminated. The reference to hospitals charging persons able to pay in the 1956 proposal is a restatement of the case law which permitted charges to persons able to pay as long as persons unable to pay were served. (See *infra*, pp. 20-24).

[13] The treasury regulation which issued in 1959 (24 Fed. Reg. 5217, 5219, June 26, 1959), and is still in effect (26 CFR 1.501 (c)(3)-(1)(d)-(2)), defines the term "charitable" thus for Internal Revenue Code purposes:

> "The term 'charitable' is used in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decisions. Such term includes: relief of the poor and distressed or of the underprivileged; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human and civil rights secured by law; or (iv) to combat community deterioration and juvenile delinquency. The fact that an organization which is organized and operated for the relief of indigent persons receives voluntary contributions from the persons intended to be relieved will not necessarily prevent such organizations from being exempt as an organization organized and operated for charitable purposes . . ."

Revenue Bulletin No. 1975-10). As stated in the lead ruling:

> "Charitability is also dependent upon the fact that the service provided by public interest law firms is distinguishable from that which is commercially available. *It is a general rule of charity law that the providing of an ordinary commercial service to the members of a community, even if done on a not-for-profit basis, is not regarded as charitable.*" (emphasis supplied) Rev. Rul. 75-74.

A public interest law firm that charges *any* of its clients would lose its charitable status (Rev. Rul. 75-75), and even those public interest law firms which limit fees to those awarded by a court or administrative agency may lose their charitable status if the cases they take have "the strong possibility of recovery of fees." (Rev. Rul. 75-76).

Similarly, IRS has ruled that a nonprofit organization formed to provide managerial and consulting services at cost to unrelated exempt organizations does not qualify for exemption as "charitable". The rationale for that ruling was stated thus:

> "Providing managerial and consulting services on a regular basis for a fee is trade or business ordinarily carried on for profit. The fact that the services in this case are provided at cost and solely for exempt organizations is not sufficient to characterize this activity as charitable within the meaning of section 501(c)(3) of the Code. *Furnishing the services at cost lacks the donative element necessary to establish this activity as charitable.*" (emphasis supplied). Rev. Rul. 72-369, Cum. Bull. 1972-2, p. 245-6.

In the housing market, IRS also has drawn a distinction between those nonprofit organizations which aid persons who cannot obtain conventional loans because of their poverty and/or which have programs designed to eliminate

prejudice, discrimination, and community deterioration, and those nonprofit organizations formed to provide moderate income families with housing at cost. The former are "charitable", but the latter are not, as the latter "program is not designed to provide relief to the poor or to carry out any other charitable purpose within the meaning of the regulations applicable to section 501(c)(3)." See Rev. Rul. 70-585, 1970-2 Cum. Bull. 115.

In the same way, a nonprofit hospital which charges all its patients at or above cost is competing with the commercial hospital market, lacks the donative element necessary to establish its activities as charitable, and is not designed to carry out any other charitable purpose within any of the classifications set forth in the treasury regulation and therefore cannot qualify for the benefits of § 501(c)(3) and § 170(c) status.

B. The well-established judicial interpretation of the application of "charitable" to hospitals under the Internal Revenue Code requires that such hospitals afford general hospital care to persons unable to pay.

The federal courts have long recognized that the charitable status of nonprofit hospitals under the Code depends upon the provision of free and below cost care to persons unable to pay. In fact, every federal tax court decision on the subject since 1942, and continuing to date, has so held.[14] *Commissioner* v. *Battle Creek Sanitarium*, 126 F.2d 405 (5th Cir., 1942); *Inter-City Hospital Association* v. *Squire*, 56 F.Supp. 472 (W.D. Wash. 1944); *Davis Hospital, Inc.*, 4 CCH Tax Ct. Mem. 312 (1945); *Goldsby King Memorial*, 3 CCH Tax Ct. Memo. 693 (1944); *Lorain Avenue Clinic*, 31 T.C. 141 (1958); *Robert Olney*, 17 CCH Tax Ct. Memo. 982 (1958); *Sonora Community Hospital*, 46 T.C. 519 (1966), aff'd per curiam, 397 F.2d 814 (9th Cir., 1968). See also, *Harding Hospital* v. *United States*, 358 F.Supp. 805 (S.D. Ohio, 1973), aff'd 505 F.2d 1068 (6th Cir., 1974). No federal case has ever held that a nonprofit hospital or health institution was charitable *per se*, or that exacting fees as a price of service in every case did not vitiate the claim of "charitable" purpose. Ibid. See also *Hassett* v. *Associated Hospital Service Corporation*, 125 F.2d 611, 614-5 (1st Cir. 1942).

[14] The issue does not appear to have been raised earlier in cases under the federal tax laws. But see state cases, discussed *infra*, pp. 29-30.

The basic test for defining a "charitable" hospital under the Code was stated by the Court of Appeals for the Fifth Circuit over thirty years ago:

> "It is also usual for hospitals and sanitariums to charge those able to pay for services rendered, in order to pay the expenses of the institution, *while not denying treatment to others unable to pay anything*. Such institutions are classed as charitable." *Commissioner* v. *Battle Creek Sanitarium*, 126 F.2d 405, 406 (5th Cir. 1942). (emphasis supplied).

Significantly, at that time IRS was taking a position 180 degrees from that expressed in Revenue Ruling 69-545, i.e. in 1942 IRS was stating that a hospital which charged *anyone* was not entitled to status as a charitable hospital. The Fifth Circuit rejected the contention because the hospital did not deny treatment to those persons unable to pay. The record demonstrated that a significantly large percentage of the patients received services, on both an inpatient and outpatient basis, free or below cost. Payment by persons able to pay permitted the hospital to provide charitable service to persons unable to pay.

For the next twenty-seven years the *Battle Creek* rule, permitting hospitals to charge persons able to pay *while not denying admission to others unable to pay*, remained

the basic rule for the courts and the Internal Revenue Service. In *Intercity Hospital Association* v. *Squire*, 56 F.Supp. 472, 474 (W.D. Wash., 1944) the IRS denied charitable tax status to the hospital, resting its conclusion upon the dual findings that, "in practically every case a charge is made for the services rendered" and "neither your articles of incorporation nor by-laws provide for the treatment of charitable patients, and it is apparent from the evidence presented that you have no purpose and made no pretense of bestowing charity." The court in that case rejected these findings of fact as unsubstantiated, and found rather that the evidence established

> "no questions whatever were asked [of the patients] and no statement required of financial standing nor ability to pay immediately or prospectively . . . [resulting in] . . . an amount ranging from six to eight percent of such gross income . . . [being] . . . donated to charity patients." (at 474).

The tax court issued similar opinions during the same period. Thus, in *Davis Hospital*, 4 CCH Tax Ct. Memo. 312 (1945) it deemphasized the stress which the Commissioner had placed upon the fact that the hospital charges those able to pay for the services rendered, stating

> "This is the usual practice of hospitals. *So long as admission and treatment are not denied to those unable to pay*, an institution is classed as charitable." (At 315).

See also, *Goldsby King Memorial*, 3 CCH Tax Ct. Memo. 693 (1944).

This was the state of the law when the IRS issued Revenue Ruling 56-185. That ruling was a "codification" of the *existing* legal requirements of the Code, as set forth in legal decisions, permitting nonprofit hospitals to charge those able to pay but requiring admission and

services to persons who could not pay. Specifically, the ruling required that a qualifying hospital

> "(m)ust be operated to the exent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay. *It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay.* The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may also set aside earnings which it uses for improvements and additions to hospital facilities. *It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services.* Furthermore, if it operates with the expectation of full payment from all those who it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered." Rev. Rul. 56-185, 1956-1, Cum. Bull. 202. (Emphasis supplied).

The same approach continued to be followed subsequent to the issuance of Revenue Ruling 56-185. In 1958 the Tax Court denied tax exempt status in *Lorain Avenue Clinic*, 31 T.C. 141 (1958), but granted it in *Robert C. Olney*, 17 CCH Tax Ct. Mem. 982 (1958). In *Olney* the two cases were compared, the court distinguishing *Lorain Avenue Clinic* in that

> "charitable services as were required . . . were occasional and of too minor volume to qualify petitioner for exemption [where] in the instant case . . . the hospital has numerous charity patients and was operated on a charitable basis to the extent of its financial ability" (at 993).

Again in *John J. Cranley, Jr.*, 20 CCH Tax Ct. Mem. 20 (1961), the Tax Court rejected a claim of charitable

exemption due to the absence of any evidence as to "how many patients, if any, paid reduced or nominal charges or no charge at all" during the five year period in question. In *Sonora Community Hospital*, 46 T.C. 519 (1966), aff'd *per curiam*, 397 F.2d 814 (9th Cir., 1968), the Tax Court continued to reiterate the same theme:

> "The amount of free care as rendered by petitioner was on a de minimum level, being less than 1 percent of paid care . . . a 'charitable' hospital may impose charges or fees for services rendered, and indeed, its charity record may be comparatively low . . . but a serious question is raised *where its charitable operation is virtually inconsequential.*" (At 526, emphasis supplied).

Most recently, in *Harding Hospital* v. *United States*, 505 F.2d 1068 (6th Cir., 1974), affirming 358 F.Supp. 805 (S.D. Ohio, 1973), the Sixth Circuit indicated that plans and policies for the admission of charity (i.e., nonpaying) patients continue to be a significant ingredient for the retention by a nonprofit hospital of its "charitable" status under the Code.

No federal case has ever held that a nonprofit hospital which limits general hospital care to persons able to pay is "charitable" within the meaning of the benefits provisions of the Code. Every federal tax case has considered service to the persons unable to pay as a *sine qua non* of "charitable" status for nonprofit hospitals.

C. Legislative history establishes that Congress rejected proposals to relieve "charitable" hospitals of the obligations under the Internal Revenue Code to provide hospital care to persons unable to pay.

The defendants are trying to amend the Code in disregard of the intention of Congress. On two occasions (in 1924 and in 1969) attempts were made to extend the benefits of the tax exempt and deduction provisions

to health instittuions apart from their charitable status, and on both occasions the attempts were rejected.

In 1924, the Senate rejected a proposal to broaden the term charitable by including social service and benevolent type activities including health. Senator Willis of Ohio, referring to a ruling of the IRS [15], proposed to add parenthetical language after "charitable" so as to include "preventive and constructive service for relief, rehabilitation, health, character building, and citizenship." (65 Cong. Rec. 8171 (1924)). The amendment was withdrawn after it became clear that the sentiment of the Senate, and the senators who would take the bill to conference, was against the broad sweep of the parenthetical language. (65 Cong. Rec. 8172-3).

The issue arose again in 1969, when Congress specifically addressed the question whether nonprofit hospitals should be added as a separate category under sections 501(c)(3) and 170(c). At hearings before the House Ways and Means Committee in February 1969, representatives of the American Hospital Association (AHA) testified that the mere provision of health care by nonprofit institutions is worthy of tax exempt and tax deduction status *per se*, and the requirement that such hospitals afford service to the indigent was archiac. (Hearings on the Tax Reform Act of 1969, H.R. 13270, Before the House Committee on Ways and Means, 91st Cong., 1st Sess. 1425, 1428, 1433 (1969)). The House bill, as reported in August 1969, accepted the AHA

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[15] In the ruling to which Senator Willis referred, the Commissioner, after noting that "in dealing with charitable trusts or uses the courts have tended to give a very broad meaning to the term 'charitable' on the ground that it was expedient to uphold such trusts or uses," stated that charitable for internal revenue purposes was more restrictive, i.e., used "in its popular and ordinary sense [which] pertains to the relief of the poor." Int. Rev. Bull. II-1-2 (1923), Ruling II-2-1128 I.T. 1800, 152, 153. Although Senator Willis referred to an earlier, contrary position by the predecessor Commisisoner, we have been totally unable to find any such ruling.

proposal, and provided that "hospitals" be added to the list of organizations under 501(c)(3) and 170(c), thus freeing hospitals from the requirement of giving charitable service. (House Report No. 413, 91st Cong., 1st Sess. 43 (1969)).

In October, while the Senate Finance Committee was considering the legislation, IRS issued Revenue Ruling 69-545. Two weeks later the Senate Finance Committee considered the issue, and clearly rejected the change in the Code proposed by the House bill and represented by the ruling at issue in the instant case. (S. Rep. No. 91-552, U.S. Code and Cong. News, 91st Cong., 1st Sess. 2089-90, 1969). The Senate passed the bill without the change giving hospitals separate status apart from the charitable category, and the final Act, after conference committee consideration, followed the Senate version. (Conference Report 91-782, 91st Cong., 1st Sess. 289-90 (1969)).

The court below concluded that the 1969 legislative history cannot be interpreted as a congressional disapproval of Revenue Ruling 69-545. (See Pl. Pet. 26a). That is a misreading of legislative history. The Senate Finance Committee rejected the provision and the House accepted the rejection of its previously passed amendment.

The Senate Report explains the deletion of the House amendment which added hospitals as a separate category under 170(c) and 501(c)(3):

> "The Internal Revenue Service has, . . . issued a ruling on October 8, 1969, indicating that hospitals, if they meet all the other requirements of section 501(c)(3), are exempt under that provision, whether or not they provide charitable services on a no-cost or low-cost basis."
>
> "Explanation of provisions—*The committee deleted from the bill those provisions which would have conformed the code to the result reached by the 1969 ruling.* The Committee decided to reexamine this matter in connection with pending legislation on Medicare and Medicaid." S. Rep. No. 91-552, U.S. Code Cong. & Admin. News, 91st Cong., 1st Sess. 2089-90, (1969) (emphasis supplied).

The Senate Finance Committee recognized that the 1969 ruling does *not* conform to the Code. Since defendants do not have any power to amend a congressional enactment, this statement in the Senate Report means that the ruling is *ultra vires*, as out of conformity with the Code. To the extent that there was any consideration by the Senate of this issue, it was with the representation as set forth in the committee report that the 1969 ruling did not conform to the Code, and that prior to any such change, the impact on the operation of the Medicaid and Medicare programs would have to be assessed.

The history in the House lends even less support to defendants. The House, which earlier had passed the amendment, and obviously assumed that it was *needed* in order to qualify hospitals for the tax benefits of these provisions without regard to service to the poor, accepted the deletion of the provisions. The Conference Report stated,

> "The House bill provides that hospitals, if they meet all other requirements of section 501(c)(3), are exempt under that provision, whether or not they provide charitable services on a no-cost or low-cost basis. The Senate Amendment strikes out these provisions."
> "The Conference substitute (sec. 101(j) of the substitute and sec. 501(c)(3) of the Code) follows the Senate Amendment." (Conference Report 91-782, U.S. Code Cong. & Admin. News, 91st Cong., 1st Sess. 2404 (1969)).

There is no mention of Revenue Ruling 69-545, let alone any suggestion that the House decided it did not need to

make the amendment because the defendants had issued Revenue Ruling 69-545. On the contrary the House, by agreeing to the deletion of the amendment, indicated that the earlier position was still the law of the land.

A subsequent Senate Finance Committee Staff report, issued two months after the final passage of the Tax Reform Act of 1969, explains why the ruling was rejected by the Senate Finance Committee. (See, *Medicare and Medicaid, Problems, Issues, and Alternatives*, Report of the Staff to the Committee on Finance, U.S. Senate, 91st Cong., 1st Sess. (Feb. 9, 1970), chap. 4). (App. 39-46). The Staff Report, after seriously criticizing the ruling,[16] refers to the opposition by the National Governors' Conference to the House Amendment. The Report then noted that recent transfers of indigent patients from the emergency rooms of nonprofit hospitals to D.C. General Hospital appeared to reenforce the anxiety expressed by the National Governors' Conference that the ruling and the House amendment would be detrimental to the operation of the Medicare and Medicaid programs and the availability of hospital services to the poor.

In sum, Congress rejected the AHA proposal that nonprofit hospitals enjoy § 170(c) and § 501(c)(3) tax benefits without providing charitable care. Defendants lack the power to amend the Code and confer benefits which Congress so specifically denied.

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[16] Referring to the representations of the American Hospital Association before the Committee on Ways and Means in October 1969, to the effect that nonprofit hospitals, unlike the rest of the private sector, extend their services to the entire community "regardless of the ability to pay," the Staff Report categorically states that a hospital (as described in the ruling) which excludes persons unable to pay from all but emergency room service is clearly not extending its service to the entire community. (App. 44-46).

D. The law of charitable trusts does not support the defendants.

In Revenue Ruling 69-545 defendants totally ignored the federal precedent discussed *supra*, pp. 20-24, and relied simply on general statements in treatises governing charitable trusts. (See *infra*, pp. 13a, 14a) But the defendants' interpretation of trust law is incorrect.

The trust law cases, including most of those cited in support of the statements in the treatises, do not hold that charitable hospitals may limit their services to persons able to pay, but stand for the same proposition as the federal tax cases, either that the rich *as well as* the poor may be treated at a "charitable" hospital, or that the hospital, home for the aged, or health facility must not exclude the indigent or its purpose is not "charitable." See, e.g. *Hart* v. *Taylor*, 301 Ill. 344, 133 N.E. 857, 858 (1922); *O'Brien* v. *Physicians' Hospital*, 96 Ohio St. 1, 116 N.E. 975, 977 (1917); *Cleveland Osteopathic Hospital* v. *Zangerle*, 153 Ohio 222, 223, 91 N.E. 261, 263 (1950); *Methodist Old People's Home* v. *Korzen*, 39 Ill. 2d 149, 233 N.E. 2d 537 (1968); *Ruston Hospital* v. *Riser*, 191 So. 2d 664 (La. 1966); *Presbyterian Homes* v. *Division of Tax Appeals*, 55 N.J. 275, 261 A.2d 143 (1970); *Catholic Charities* v. *City of Pleasantville*, 109 N.J. Super 475, 263 A.2d 803 (1970). And state cases continue in 1975 to hold that the poor may not be excluded from charitable hospitals. See, *Jackson County, Missouri* v. *State Tax Commission*, 521 SW2d 378 (Mo. 1975). Although some states have adopted the proposition that charitable hospitals need not serve the poor under the provisions of their local

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[17] That court reversed the administrative findings of fact that the three nonprofit hospitals did not serve the indigent, and, concluding that the evidence demonstrated that the hospitals were available to all, both rich *and poor*, found them qualified as charitable institutions. The court specifically rejected the notion that hospital care for the sick and infirm is a charitable purpose in and of itself. 521 SW2d at 383, 385.

laws (e.g., as cited by the court below, the State of Nebraska, in *Evangelical Lutheran Good Samaritan Society* v. *County of Gage*, 181 Neb. 831, 151 N.W. 2d 446, 449 (1967)), this is not the general rule for the law of trusts. (E.g., see above cited cases).

Further, there is nothing novel in the statements appearing in the cited treatises (3rd edition of Scott, 1967 and the 2nd edition of the Restatement on Trusts, 1959) (of which Scott was the principal reporter)), upon which defendants relied in Revenue Ruling 69-545. Earlier editions of Scott back to 1939 contain identical statements. Compare IV Scott on Trusts (3rd ed. 1967), sec. 368 and sec. 372.2 with IV Scott on Trusts (1st ed., 1939) and with IV Scott on Trusts (2nd ed., 1956). Obviously the statements were considered incorrect, irrelevant and/or not controlling for tax purposes during the development of federal tax precedent in the 1940s and 1950s.

E. The court before improperly relied on its own views of the health needs of the poor, and these views are, in any event, factually incorrect.

The court below justified the elimination of the free service requirement, not on the trust analogy used by defendants but upon the court's own conjectures as to the current needs of the poor for care by hospitals. Specifically, the court concluded that Revenue Ruling 69-545 reflected a "permissible" definition of charitable service upon two premises: (1) that the rationale for requiring hospitals to afford free and below cost services to persons unable to pay, i.e., the existence of a large number of poor persons without any public or private insurance coverage, has largely disappeared (Pl. Pet. 25a); and (2) Revenue Ruling 69-545, with its requirement of an open emergency room, may be of greater benefit to the poor than the requirements set forth in Revenue Ruling 56-185 (Pl. Pet. 27a).

These premises are vulnerable from two standpoints. First, Revenue Ruling 69-545 is entirely devoid of any reference to the needs of indigent persons for general hospital care and/or any evaluation of the beneficial value of an open emergency room compared to the availability of general hospital care.[18] This court has long held that an appellate court cannot substitute its own determination of policy, or the *post hoc* rationalization of appellate counsel,[19] for the grounds relied upon by the administrative agency. See, *S.E.C.* v. *Chenery Corp.*, 318 U.S. 80, 87 (1943); *Burlington Truck Lines, Inc.* v. *United States*, 371 U.S. 156, 168-9 (1962); *Bell* v. *United States*, 366 U.S. 410 (1961); see also, *Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402, 419 (1971); *Camp* v. *Pitts*, 411 U.S. 138, (1974).

Secondly, the two premises are unsupportable. The first premise suggests that there are few if any poor people lacking means to pay for health care. That conclusion is without any basis in fact. Millions of poor people continue to be uncovered by any private or public health insurance program and are unable to pay for health and hospital care because of their own limited resources. Although the Medicaid program (42 U.S.C. 1396 *et seq.*) was theoretically designed to provide health coverage for the poor, it has been largely confined to the categorical public assistance recipients,[20] and, in ap-

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[18] Nor could defendants, tax experts, have determined these health system premises as a matter of agency expertise. Appellate counsel for defendants before the court of appeals acknowledged that "the experience [of the Commissioner of Internal Revenue] in the area of health care is severely limited." (Def. C.A. brief, p. 72).

[19] The premise that the emergency room service may be more valuable to the poor seems to come from appellate counsel's *post hoc* rationalization before the court of appeals. (Def. C.A. brief, p. 72).

[20] The categories are: the aged, the totally disabled, the blind, and children deprived of parental support by virtue of the death, disability, or absence of one parent. 42 U.S.C. 1396a(10)(A).

proximately half the states, to similar persons with incomes somewhat above the public assistance level.[21]

The levels of eligibility are abysmally low,[22] in most states far below the poverty guidelines which themselves are below subsistence.[23] In a state such as Louisiana, where Plaintiffs Cook, Hunter, and Lampton reside, eligibility for Medicaid depends upon eligibility for welfare, and the cut-off for welfare eligibility was an annual income for a family of four in excess of $1464 a year under the most recently available figures.[24] The family income for Plaintiff Hunter as of January 1973, ($196 per month for her and her five children), make her and her children (including two with acute sickle cell anemia) too "rich" for Medicaid. (App. 91).

Plaintiffs Henry and Carolyn Block reside in Arizona (App. 85-86), which is scheduled to institute a Medicaid program for the first time in October 1975. Even then, unless Arizona raises its welfare level substantially above the most recently published level ($2,208 for a family of four as of July 1974)[25], a large portion of the very poor who otherwise fit the public assistance categories will continue to be excluded. Plaintiffs Henry and Carolyn Block, and their three children, with an approximate $2,400 a year income (App. 85), will continue to be excluded, if not by their income, then because they are an "intact" family and do not fit into any of the public assistance categories.

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[21] See, Pl. Pet. 77a-79a for chart setting forth state-by-state levels for Medicaid eligibility.

[22] *Ibid.*

[23] The most recent figures set the poverty guidelines at $5050 for a family of four. 40 Fed. Reg. 14317-8 (1975).

[24] Pl. Pet. 77a-79a.

[25] Pl. Pet. 77a, n.3.

The U.S. Department of Health, Education and Welfare (hereinafter HEW), which is the designated federal agency expert in matters of determining health needs and health policy, has commented thus upon the inadequacies of the Medicaid program to cover all the poor:[26]

> ". . . Eligibility for Medicaid also poses financial barriers. Eligibility varies widely among the States, many of which exclude the working poor and adults in families headed by a male. Under these circumstances, half the families with incomes under $5000 a year and two-thirds of the families with incomes under $3000 have no insurance. Others excluded from protection are: children and mothers in low-income and middle-income families; the unemployed and their dependents; lower income self-employed people; employed people (mainly the working poor) whose employers offer no health plans; and migrant and seasonal workers."

HEW estimates that there are some 41 million Americans under the age of 65 who have no economic protection through private insurance against hospital costs,[27] only 17.4 million of whom are covered by Medicaid.[28] Most

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[26] Towards a Comprehensive Health Policy for the 1970's, A White Paper, May 1971, U.S. Department of Health, Education and Welfare, p. 16.

[27] See Mueller, Private Health Insurance in 1973: A Review of Coverage, Enrollment, and Financial Experience, Social Security Bulletin, U.S. Department of Health, Education and Welfare, February 1975, pp. 21-22. This estimate is, of course, prior to the recent upsurge of unemployment with its consequential losses of health insurance benefits by the recently unemployed.

[28] *Ibid.* Mueller indicates that 20.9 million persons had payments made on their behalf under Medicaid in fiscal year 1973, 16.8 percent of whom were over 65. We substracted persons over 65, as the basic figure (the 41 million) referred only to those under 65. (Persons over 65, whether poor or not, are, with some exceptions, covered by Medicare, the health insurance program for the aged, 42 U.S.C. 1395. Medicare however does not fully pay for health and hospital care for the aged, and some of the aged also would fall

of the 23.6 million without either private insurance or Medicaid coverage are clearly those too poor to pay for hospital care through their own resources.[29]

In addition to those poor who are not covered by any private or public health insurance program, an unknown number of low income people are covered by inadequate insurance which deprives them of admission to hospitals which require full payment. According to a comprehensive health insurance report by the staff of the House Ways and Means Committee, three-tenths of the expenditures for hospital care are not covered by insurance. (See, Basic Facts on the Health Industry, prepared for the use of the Committee on Ways and Means, 92nd Cong., 1st Sess., June 28, 1971, p. 104).

The second premise upon which the court justified its departure from precedent was the unsupported surmise that the provision of emergency room service to all may

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between the cracks, too rich for Medicaid but without any additional resources to pay for the health and hospital care not covered by Medicare).

[29] The poorer a person is, the less likely it is that he has health insurance.

In this regard, HEW provides the following information as to hospital insurance coverage of persons under 65 in 1968:

Family Income class (dollars)	Percentage of persons under 65 with hospital insurance	Percentage of persons under 17 with hospital insurance
Under 3,000	36.3	23.3
3,000-4,999	56.8	49.0
5,000-6,999	78.5	74.6
7,000-9,999	89.3	88.4
10,000 & over	92.3	91.8

Department of HEW, National Center for Health Statistics, Hospital and Surgical Insurance Coverage, United States—1968, Series 10, No. 66 (1972), pp. 18-19.

be more beneficial to the poor than a requirement of free and/or below cost general hospital care. This surmise was made by the court without any consideration of where the poor would receive general hospital services beyond the provision of emergency room care.[30]

Neither the defendants nor the court below considered whether alternative hospital care would be available for the indigent in communities which lack public charity hospitals. Many of the medium-sized communities of the United States are served by only nonprofit or for-profit hospitals—there are no public charity hospitals in such cities. Examples of such communities include: Topeka, Kansas; Peoria, Illinois; Springfield, Missouri; Charlotte, North Carolina; Spokane, Washington; Duluth, Minnesota; and the northern Virginia suburbs of Washington, D.C.[31] The same is true in rural communities, such as those in which the Kentucky plaintiffs reside.[32] Revenue

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[30] Most recently the Supreme Court rejected the distinction made between necessary-but-elective hospitalization and emergency hospitalization:

> "The State could not deny Evaro care just because, although gasping for breath, he was not in immediate danger of stopping breathing altogether. To allow a serious illness to go untreated until it requires emergency hospitalization is to subject the sufferer to the danger of a substantial and irrevocable deterioration in his health. Cancer, heart disease, or respiratory illness, if untreated for a year, may become all but irreversible paths to pain, disability and even loss of life. The denial of medical care is all the more cruel in this context, falling as it does on indigents who are often without the means to obtain alternative treatment."
>
> *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250, 260-1 (1974).

[31] See chart, *infra*, pp. 17a-18a.

[32] Prestonburg General (d/b/a Highland Regional Medical Center) and Pikesville Methodist are the only hospitals in their respective communities. American Hospital Association Guide to the Health Care Field, 1974 Edition, p. 10. During its fiscal year 1971-2 Pikesville Methodist treated some 8,110 patients on a regular admission basis, only 24 of whom were treated free (App. 165-6). The administrator of that hospital admitted in a meeting with

Ruling 69-545 means that the only available hospitals in these and other similar communities have no legal obligation to provide persons unable to pay with general hospital care.

But the lack of alternative hospital facilities is not limited to communities without any public charity hospitals. Even in communities with publicly-owned charity hospitals there are an inadequate number of beds to serve the indigent.[33] For example, New Orleans, where plaintiffs Hunter, Cook, and Lampton reside, has a large charity hospital, but it serves the indigent of the entire state of Louisiana, and cannot accommodate all indigent persons needing hospitalization. The record in this case includes the affidavits of physicians who have continually been forced to turn away from that charity hospital 35 to 50 persons a day (App. 126) who, in their judgment as physicians, should be hospitalized. (App. 125-144, 116).[34] Plaintiffs Hunter, Cook and Lampton have attempted to be admitted for hospital care at various nonprofit hospitals in New Orleans, but have been turned away because they lacked the means to pay. (App. 98-9, 103-5, 112-3).

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members of the health committee of Plaintiff EKWRO that the admission practice is, "if they don't have the money, they don't get in." (App. 79-80). Persons unable to pay have been turned away from admission into Pikesville Methodist for necessary surgery (App. 84).

[33] The inadequacies of the understaffed, under-equipped, and underfinanced public hospitals have been extensively domunented. See, July 1970 Issue of Hospitals (the official publication of the American Hospital Association) devoted entirely to "The Plight of the Public Hospital." See also, Rose, *The Internal Revenue Service's "Contribution" to the Health Problems of the Poor*, 21 The Catholic Un. Law Rev. 35, 36, fn. 3.

[34] As the record in this case demonstrates, and the opinion of this Court in *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250, 260-1 (1974) recognized, the unavailability of inpatient hospital care may make inevitable the road to death. (See, App. 116-121, 96, 122-124 documenting the rejection of admission for inpatient care by nonprofit hospitals because of lack of ability to pay of two persons who soon thereafter died.)

Even the requirement that a hospital provide an open emergency room is illusory. Those hospitals not located within poverty areas would rarely, if ever, be called upon to provide emergency treatment for the poor. Obviously, the pressing need for emergency care does not allow the poor the time nor the means to travel to outlying hospitals. However, the poor would utilize these hospitals for necessary "elective" care such as obstetrics and general surgey, particularly if the nearby charity hospitals were over-crowded and understaffed.

Further, under the ruling, hospitals are free to patch up patients in the emergency room and then transfer them to charity hospitals rather than admit them. (See *infra*, pp. 11a-12a). Such transfers to public charity hospitals may be medically detrimental, as recognized by physicians (App. 131-2) but not by defendants and the court of appeals. This transfer arrangement, which has been given the less delicate name of "dumping",[35] was one of the concerns of the Senate Finance Committee at the time that Committee rejected the House amendment. (See App. 43).

The speculations of the court as to the needs of indigent persons without means to pay for hospital care and the beneficial value of emergency room service compared to the availability of general, across-the-board hospital care are unsupported by the record and have little relationship to the health needs of the poor.

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[35] In this regard in the July 1970 issue of HOSPITALS, its feature editor states:

> "Whereas the 'mainstream' of health care during the 1950s and early 1960s was progressive and represented by research-oriented medical centers, public hospitals became the 'dumping grounds' for the medically indigent and had come to be identified with a dual standard of health care delivery. The passage of Medicare and Medicaid legislation in the mid-1960s was expected to unify the dual system. Unfortunately, the private sector has not absorbed its proportionate share of the sick poor" HOSPITALS (AHA), July 1, 1970, at 54.

F. Neither defendants nor the court below considered the health policy of the United States as expressed by congress and the health agency of the United States.

As recognized by the court in *Green* v. *Connally*, 330 F.Supp. 1150 (D.D.C., 1970), aff'd *per curiam sub nom. Coit* v. *Green*, 404 U.S. 997 (1971),

> ". . . the ultimate criterion for determination . . . [of] eligibil[ity] . . . under the 'charitable' organization provisions of the Code rests not on a common law referrant but on . . . Federal policy." (At 1161).

Federal health policy presupposes and requires that non-profit hospitals provide free care to the indigent.

The United States is the only industralized country in the world without a publicly-financed universal health insurance system. Rather than providing publicly-financed national health insurance, Congress has endorsed a mixed system. The federal government provides incentives to the private sector—direct subsidies (such as Hill-Burton grants)[36] and indirect tax subsidies—and the private sector provides health and hospital care to the poor.

While defendants and the court below were defending the abandonment by IRS of the charitable obligation of non-profit hospitals to the millions of uninsured indigent persons, HEW was reaffirming the charitable obligations of those hospitals which had received Hill-Burton construction monies.[37] In July 1972 and June

[36] 42 U.S.C. 291 *et seq.*, Title VI of the Public Health Service.

[37] Nonprofit hospitals are eligible for Hill-Burton grants. However, a significant percentage of nonprofit hospitals have not received any Hill-Burton monies (about 40%) and are therefore not subject to the "free service" requirements of that program. Other nonprofit hospitals received Hill-Burton monies over 20 years ago, and the obilgation no longer applies. 42 CFR 53.111(a). Other nonprofit hospitals received very small grants, and accordingly have very small Hill-Burton obligations (42 CFR 53.111(d)) which have no relationship to the size of charitable contributions received.

1973, HEW promulgated regulations setting forth more specific guidelines defining the obligations of Hill-Burton hospitals to serve persons unable to pay.[38] And Congress in December 1974 reaffirmed the obligations of such hospitals by including in the new Title XVI of the Public Health Service Act provisions which continue HEW's duty to enforce the Hill-Burton obligations and require new obligations for all future grantees.[39]

Thus, Revenue Ruling 69-545 was issued without any consideration of the health policies as expressed generally by Congress and HEW.

G. The power of defendants to administer the Internal Revenue Code does not include the power to amend the Code.

This Court has held on inumerable occasions that the power of the Commissioner of Internal Revenue

[38] 42 CFR 53.111, 37 Fed. Reg. 14719 (1972); 38 Fed. Reg. 16353 (1973). The Hill-Burton standards are set forth in the alternative, one measure of which is the size of the grant. 42 CFR 53.111 (d). Similarly, the obligation of a nonprofit hospital during any given year might be measured by the size of charitable donations to it, and a proportion of its otherwise taxable income.

[39] National Health Planning and Resources Development Act of 1974, P. Law 93-641, sections 1602(5) and (6), 1604(b)(1)(J), and 1612(c). (Title XVI of the Public Health Service Act (January 4, 1975)). In June 1974, the chairman of the Health Subcommittee of the Senate, in introducing that Subcommittee's health facilities bill (which ultimately became part of Public Law 93-641), stated with regard to the free service obligations of Hill-Burton hospitals (and referring to the district court decision in the instant case which declared Revenue Ruling 69-545 void):

> "Until the ability to pay is totally eliminated as a criterion of access in our society, the 'free service' assurance will have to be enforced. A similar requirement regarding the provision of services to those unable to pay for such services for hospitals which seek the benefits of 'charitable' status under the Internal Revenue Code has also recently been recognized by a Federal court here in the District of Columbia." 121 Cong. Rec. S.9538 (June 4, 1975).

> "is not the power to make law . . . but to adopt regulations to carry into effect the will of Congress as expressed by the statute. A regulation which does not do this, but operates to create a rule out of harmony with the statute, is a mere nullity." *Manhatten General Equipment Co.* v. *Commissioner*, 297 U.S. 129, 134 (1936); *Dixon* v. *United States*, 381 U.S. 68, 74-75 (1965).

See also, *United States* v. *Cartwright*, 411 U.S. 546, 550 (1973); *Fribourg Navigation Co.* v. *Commissioner*, 383 U.S. 272 (1966); *Corn Products Refining Co.* v. *Commissioner*, 350 U.S. 46, 52-3 (1955), motion for rehearing denied, 350 U.S. 943 (1956); *United States* v. *Leslie Salt*, 350 U.S. 383, 396-7 (1955).

But "make law" is precisely what the defendants have done in the instant case. The judicial, administrative, and legislative history of the application of "charitable" under sections 501(c)(3) and 170(c) to nonprofit hospitals requires such institutions to provide services to persons unable to pay.

In *Fribourg Navigation Co.* v. *Commissioner*, 383 U.S. 272 (1966) the Supreme Court admonished the Commissioner for a similar amendment to the Code and found that he had exceeded his statutory authority:

> "Over the same extended period of years during which the foregoing administrative and judicial precedent was accumulating, Congress repeatedly reenacted the . . . provision without significant change. Thus, beyond the generally understood scope of the . . . provision itself, the Commissioner's long standing and consistent administrative practice must be deemed to have received congressional approval." (At 283).

See also, *United States* v. *Leslie Salt*, 350 U.S. 383, 396-7 (1956); *Corn Products Refining Co.* v. *Commissioner*,

350 U.S. 46, 52-3 (1955) motion for rehearing denied, 350 U.S. 943 (1956). The same admonishment is applicable in the instant case.

Neither a proper reading of the trust law analogy, the realities of the health needs of the poor, or the health policies of Congress and HEW, renders reasonable defendants' departure from precedent. Defendants have simply usurped congressional power and rewritten the law.

II. THE DEFENDANTS VIOLATED THE RULE-MAKING REQUIREMENTS OF THE ADMINISTRATIVE PROCEDURE ACT.

Even if defendants did not violate the "charitable" provisions of the Internal Revenue Code, they did violate the APA by the promulgation of a major policy revision eliminating the long-standing obligation of charitable hospitals to the poor [40] without following the rule-making requirements of section 553 (5 U.S.C. 553). In addition, Revenue Ruling 69-545 was promulgated without consideration of the relevant factors necessary for informed agency action, and therefore constitutes arbitrary and capricious action or an abuse of discretion within the meaning of section 706(2)(A) of the APA. (5 U.S.C. 706(2)(A)).

Defendants contended below that Revenue Ruling 69-545 was an "interpretative" ruling, not subject to the rule-making requirements of section 553. The panel majority accepted this characterization, and also concluded that the ruling was not an abuse of discretion, again by inserting its own unsupported conjectures as to the needs of the poor and the comparative benefits of the new

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[40] One of the leading proponents of Revenue Ruling 69-545 is counsel for the American Hospital Association in this case. While an employee of the Internal Revenue Service he admitted that Revenue Ruling 69-545 was "a major revision". See, Bromberg, *The Charitable Hospital*, 20 The Cath. U. L. Rev. 237 (1970).

ruling and the prior requirement of general free service. (See Pl. Pt. 30a).

In both respects, the court erred.

A. The defendants were required to afford notice in the Federal Register and opportunity for public comment under section 553 of the APA.

Section 553 of the APA requires that an agency which engages in rule-making must do so by a general notice in the Federal Register which includes the terms or substance of the proposed rule or a description of the subjects and issues involved, and must give interested persons an opportunity to participate in the rule-making process (5 U.S.C. 553).

Defendants do not claim that the Department of the Treasury or the Internal Revenue Service are not "agencies" within the meaning of the APA, or that they are not subject to the rule-making requirements of section 553. Defendants claim, however, that their major policy revision could be promulgated without notice and comment period because it was an interpretative rule and therefore excepted from the requirements of section 553.

But whether a particular rule is governed by the requirements of section 553, or comes within one of its exceptions, is not determined by the label which the agency places upon the rule. See, e.g., *Lewis-Mota* v. *Secretary of Labor*, 469 F.2d 478, 481-2 (2nd Cir. 1972); *Texaco, Inc.* v. *Federal Power Commission*, 412 F.2d 740, 744 (3rd Cir. 1969); *Hou Ching Chow* v. *Attorney General*, 362 F.Supp. 1288, 1292 (D.D.C. 1973). Case law makes clear that Revenue Ruling 69-545 is not an interpretative rule.

Several federal courts have addressed in recent years the subject of which rules of an agency are governed by the requirements of section 553, and

which are excluded by reason of one of the exceptions. Out of these cases have emerged criteria applicable to all the exceptions. These criteria are: (1) does the rule have a substantial impact upon the regulated industry; (2) does the rule have a substantial impact upon the public (or segment of the public); (3) is there a drastic change in the law as it existed before the rule was issued; (4) is there a need for the agency to educate itself. See, *Texaco, Inc.* v. *Federal Power Commission, supra; Lewis-Mota* v. *Secretary of Labor, supra; National Motor Freight Traffic Ass'n* v. *United States*, 268 F.Supp. 90 (D.D.C. 1967); *Pharmaceutical Manufacturers Ass'n* v. *Finch*, 307 F.Supp. 858 (D.Del. 1970); *Seaboard World Airlines* v. *Gronouski*, 230 F.Supp. 44 (D.D.C. 1964); *Kelly* v. *U.S. Dept. of Interior*, 339 F. Supp. 1095 (E.D. Cal. 1972); *Hou Ching Chow* v. *Attorney General, supra.* See also, *NLRB* v. *Wyman-Gordon Co.*, 394 U.S. 759 (1969).

In two 1970 cases the U.S. District Court in Delaware applied these criteria to determine whether a rule was legislative, and thus subject to 553 requirements, or interpretative, and thus exempted. In *Pharmaceutical Manufacturers, supra*, the underlying issue involved the tests which would be required to evaluate the effectiveness of all drugs currently on the market. The record demonstrated that the regulations in effect from 1938 through 1962 required different tests from those required by the challenged rule. After describing the substantial impact of the challenged rule on both the regulated industry and the public, and noting that the notice and comment requirements enabled the agency promulgating the rule to educate itself, the court found that notice and opportunity for public comment were required.

Conversely, in *Continental Oil Company* v. *Burns*, 317 F.Supp. 194 (D.Del., 1970), the same court found that the challenged rule was limited to an interpretation of a regulation which had not yet become effective. Since

the law (the Truth in Lending Act) and the regulation were new, and the rule did not cause any drastic change in the law, the rule was held to be interpretative.

In the instant case the ruling constituted a reversal of a long-contrary and judically-accepted policy. (See *supra*, pp. 20-24). The ruling clearly has a substantial impact upon the way hospitals are permitted to provide service to the poor, and upon the ability of persons unable to pay to obtain hospital care.

Moreover, defendants are not experts in health care delivery problems; they certainly needed to educate themselves before they could even consider such a significant action in this field. In this regard, it should be noted that HEW, the health agency, in promulgating standards and procedures for the free care requirements under the Hill-Burton Act, not only has given section 553 notice and opportunity for comment[41] but also held a public hearing.[42] No less should be required of an agency which ventured into the health care field without any expertise.

Case law with respect to the other exceptions from the application of the notice and comment requirements also demonstrates that the APA was violated in this case.

In *Lewis-Mota* v. *Secretary of Labor*, 469 F.2d 478 (2nd Cir. 1972) the agency argued that a directive which

[41] 37 Fed. Reg. 7632 (1972); 37 Fed. Reg. 14719 (1972). HEW has continued to follow section 553 requirements for further aspects of the "free service" (40 Fed. Reg. 10686 (1975)) and companion "community service" requirements (39 Fed. Reg. 1446 (1974)).

[42] 37 Fed. Reg. 20878 (1972). Representatives of the hospital industry, representatives of poor people such as the National Welfare Rights Organization (the parent organization of plaintiffs EKWRO and CWRO), and organizations such as the American Public Health Association, the American Federation of State, County and Municipal Employees, and the National Urban League made statements at the hearing. (Transcript of hearing "In the Matter of: Federal Hospital Council," DHEW, Oct. 20, 1972). Similar comments filed with IRS would have "educated" IRS and given that agency the opportunity to assess the impact of the ruling and its wisdom before becoming committed to it.

suspended precertification lists for aliens granted the right to work in the United States was merely "a general statement of agency policy or procedure." The Second Circuit, rejecting the label which the agency put upon its exercise of administrative power, stated that the real test was what the action in fact accomplished:

> "We find that it changed existing rights and obligations . . . By virtue of this substantial impact both upon the aliens and employers, notice and opportunity for comment by the public should first be provided." (At 482).

That court (at 482) also noted that the publication requirement of section 553 "enables the Agency promulgating the rule to educate itself," (quoting *Texaco, Inc.* v. *Federal Power Commission*, 412 F.2d 740 at 744 (3rd Cir. 1969)).

In *National Motor Freight Traffic Association* v. *United States*, 268 F.Supp. 90 (D.D.C., 1967), the court rejected a claim that the establishment of an informal procedure to settle reparation claims was not subject to the rule-making requirements. The court found that the procedures, which had been voluntarily established by the agency, were not routine. Noting the importance which the agency itself attached to the procedures, the court stated:

> "That very quality of importance—to the industry and to the public—is what lies at the base of Section 4 of the APA and which informs [sic] the Congressional purpose in that law to expose proposed agency action by general rule to the test of prior examination and comment by the affected parties." (At 96).

In *Texaco, Inc.* v. *Federal Power Commission*, 412 F.2d 740 (3rd Cir. 1969) the petitioner sought review of a regulation requiring it to pay interest compounded monthly on refunds ordered by the Federal Power Commission. The Commission contended that it did not have to provide for notice and hearing because it was "un-

necessary" as that word is used in section 553(b). The court disagreed, finding that the rule could not be classified as "either minor or emergency in character." It then stated the policy of the rule-making requirements:

> "Section 553 was enacted to give the public an opportunity to participate in the rule-making process. It also enables the agency promulgating the rule to educate itself before establishing rules and procedures which have a substantial impact on those regulated. . . . These procedures must be followed when an agency is exercising its legislative function." (At 744).

In *Seaboard World Airlines, Inc.* v. *Gronouski*, 230 F.Supp. 44 (D.D.C. 1964), the government also claimed that its new policy came within an exception to the notice and comment requirements of section 553. The court rejected the claim, again noting that the policy "substantially affects outside parties, and is therefore NOT subject to the exception." (At 46). (emphasis in original).

The theme of all these cases was accepted by this Court in *N.L.R.B.* v. *Wyman-Gordon Co.*, 394 U.S. 759 (1969). The plurality opinion states:

> "The rule-making provisions . . . were designed to assure *fairness* and *mature consideration* of rules of general application." (At 764) (emphasis supplied).

See also opinion of Justice Douglas, at pp. 777-778.

The court below accepted defendants' contention that the ruling was within the interpretative exception, because it was not "legally binding." In support it cited *American President Lines* v. *Federal Maritime Commissioner*, 316 F.2d 419, 421-2 (D.C.Cir. 1963), which characterized an interpretative ruling as essentially an opinion of the legal staff of an agency which the parties and the courts are free to ignore.

The court below misapplied *American President Lines*. The plaintiff in that case could ignore the ruling of the defendant federal officials. When the defendant sought to enforce the rule, the plaintiff could challenge the rule in court. As stated in *American President Lines*, at 422,

> "Neither the *affected parties* nor the courts are bound by it unless they elect to adopt it as a correct interpretation of the statute." (emphasis supplied).

Here, by contrast, affected parties, people unable to pay for hospital care, are effectively bound by Revenue Ruling 69-545. They can not act in disregard of the rule, which has its own operating force against them. As stated by the Second Circuit in *Lewis-Mota* v. *Secretary of Labor*, 469 F.2d at 482, the rule "changed existing rights and obligations."

Further, the court below said Revenue Ruling 69-545 is not legally binding upon courts. Yet it went outside the record to postulate conceivable policy justifications for the ruling in the same way that a court would justify a statute challenged as irrational under the Constitution. See, e.g., *Kotch* v. *Board of River Boat Pilot Com'rs*, 330 U.S. 552 at 563 (1947) *Morey* v. *Doud*, 354 U.S. 457 at 464 (1957)). It is difficult to see what greater binding effect the court could have given Revenue Ruling 69-545. As stated by Chief Judge Bazelon in his dissent from the denial of plaintiffs' suggestion for *en banc* consideration,

> . . . the majority tells the plaintiffs that it will not be bound by the Internal Revenue Service interpretation of the term 'charitable' and then turns right around and upholds the Service interpretation as a permissible exercise of discretion on the basis of factual assumptions which are not supported by a record and which plaintiffs have not had an opportunity to rebut. (Pl. Pet. 3a).

B. The defendants had the legal obligation to consider all relevant factors in reaching their determination of "charitable" requirements for nonprofit hospitals.

Section 706(2)(A) of the APA (5 U.S.C. 706(2)(A)) provides that a court may set aside agency action which is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." Even if this Court concludes that the defendants' action was not subject to the rule-making requirements of section 553, it must still find that the agency action was accomplished without consideration of the relevant factors necessary for the decision.

In *Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402, 416 (1971) this Court held that governmental officials must utilize some institutional method in exercising their duties to assure that all the relevant factual information is before them. See also, *Shannon* v. *H.U.D.*, 436 F.2d 809, 819-20 (3rd Cir. 1970).

In the instant case the defendants put on blinders, and totally excluded all reference to the continued needs of poor people for access to nonprofit hospitals for general care.[43] The sole basis upon which the defendants issued Revenue Ruling 69-545 was an analogy to the law of charitable trusts as reported by treatise writers on the subject. (See, *infra*, pp. 13a, 14a).

The court below concluded that defendants did consider the needs of the poor. However the court referred only to its *own* conjectures as to the beneficial value of an emergency room and the "changed health care situation in the country." (Pl. Pet. 30a; see discussion *supra*, pp.

[43] The continued needs of poor people for access to nonprofit hospitals is surely a relevant factor. See, e.g., the action by the Senate Finance Committee which refused to make the change in the law and referred it to future consideration in context of Medicare and Medicaid, health legislation. (*Supra*, pp. 27, 28).

30-31). As discussed above (p. 30), the speculations of a court cannot substitute for the lack of consideration of relevant factors by an administrative agency.

III. THE COURTS BELOW WERE CORRECT IN HOLDING THAT THERE WERE NO JURISDICTIONAL BARRIERS TO A CONSIDERATION OF THIS CASE.

The defendants have unsuccessfully contended in the courts below that plaintiffs have no recourse to judicial review. In their petition for certiorari, defendants raise three barriers to review in this case: the Anti-Injunction provision of 26 U.S.C. § 7421(a); the exclusion of suits "with respect to Federal taxes" in the Declaratory Judgment Act (28 U.S.C. § 2201); and the doctrine of sovereign immunity. The defendants' position, more broadly, is that IRS tax rulings can only be challenged in court in a refund suit. This position means that IRS tax rulings which do not increase a taxpayer's burden are immune from judicial review, no matter how blatantly illegal or unconstitutional they might be.

The defendants' position flies in the face of the general principle that judicial review of administrative action is the rule and non-reviewability an exception which must be demonstrated by "clear and convincing evidence" of legislative intent.[44] The defendants' position is without statutory support. It is, finally, nothing more than an unwarranted assertion of the power to act without regard to the rule of law.

A. The Anti-Injunction and Declaratory Judgment Acts do not bar the present action.

The anti-injunction provision of the Internal Revenue Code, 26 U.S.C. § 7421(a), bars any "suit for the pur-

[44] See *Barlow* v. *Collins*, 397 U.S. 159, 166-167 (1970). See also *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 141 (1967); *Rusk* v. *Cort*, 369 U.S. 367, 379-80 (1962).

pose of restraining the assessment or collection of any tax. . ." The purpose of the provision is clear from its language: to prevent judicial interference with the collection of tax revenues, interference which could grind the entire government to a halt. As the Supreme Court stated in *Enochs* v. *Williams Packing and Navigation Co.*, 370 U.S. 1, 7 (1962)

> "The manifest purpose of § 7421(a) is to permit the United States to assess and collect taxes alleged to be due without judicial intervention and to require that the legal right to disputed sums be determined in a suit for a refund. In this manner, the United States is assured of prompt collection of its lawful revenue."

The narrow scope of § 7421(a) is made clear by the Court's holding in *Williams Packing*. The Court held that, despite the express language of § 7421(a), a court could grant an injunction if it was certain that under no circumstance could the Government ultimately prevail on the merits. If the Government could not ultimately prevail, the Court reasoned, the collection of lawful revenues was not jeopardized and "the central purpose of the Act is inapplicable." 370 U.S. at 7. The fact that such an injunction suit would have collateral adverse impacts on the IRS—by forcing it to defend a lawsuit—was not deemed controlling by the Court.[45]

In its two most recent interpretations of the Anti-Injunction Act, *Bob Jones University* v. *Simon*, 416 U.S. 725 (1975) and *Alexander* v. *"Americans United", Inc.*, 416 U.S. 752 (1975), this Court implicitly reaffirmed that narrow scope of § 7421(a). The Court's opinions strongly indicate that the term "assessment and collection of

[45] The Court did state that a collateral purpose of the Act was the "protection of the collector from litigation pending a suit for a refund." 370 U.S. at 7-8. In this case, of course, no suit for a refund is possible. See discussion, *infra*, pp. 51-52.

taxes" is not an ever-expanding catchall, but means precisely what it says. In *Bob Jones University*, the Court spent some three pages to demonstrate that there is "little doubt that a primary purpose of this lawsuit is to prevent the Service from assessing and collecting income taxes from petitioner." 416 U.S. at 738. In *"Americans United"* the Court stressed that "under any reasonable construction of the statutory term 'purpose' the objective of this suit was to restrain the assessment and collection of taxes from respondent's contributors." 416 U.S. at 762.

Moreover, the Court explicitly left open the possibility that there are injunctive suits against the IRS which do not involve the assessment and collection of taxes and thus are not barred by § 7421. In *Bob Jones University*, while discussing whether an injunction could issue in a refund suit, the Court stated:

> For example, it may be possible to conclude that a suit for a refund is not "for the purpose of restraining the assessment or collection of any tax . . ." and thus that neither the literal terms nor the principle purpose of § 7421 are applicable." 416 U.S. at 748 n. 22.

Obviously, plaintiffs' challenge to Revenue Ruling 69-545 does not restrain the assessment or collection of any tax. It does not interfere with the collection of revenues in any way. If anything, the invalidation of the ruling would lead to an increase in government revenues; most likely it would have no impact at all.[46]

[46] Plaintiffs seek to compel the IRS to withdraw Revenue Ruling 69-545, which would reinstate the previous ruling requiring tax-exempt hospitals to provide some free care. Their expectation is that hospitals would adhere to the previous ruling rather than face loss of exemption. Under these circumstances, the tax exempt status of the hospitals would remain the same and there would be no change in the revenues collected by the Treasury. If, on the other hand, certain hospitals lost their exemption, the Treasury would collect additional revenues from the hospitals and perhaps from their contributors as well.

Plaintiffs' Administrative Procedure Act claims are even further removed from a restraint on the assessment and collection of taxes. A court could, for example, order the IRS to permit a thirty day comment period on a proposed regulation embodying the substance of Revenue Ruling 69-545 without requiring the IRS to alter the status of any hospital or contribution. Interested and affected persons would thus be given the opportunity to educate the IRS, as required by 5 U.S.C. § 553,[47] and the IRS would then be free to promulgate its position in proper regulation form.

In short, neither plaintiffs' substantive nor procedural claims involve a restraint on the assessment and collection of taxes. Plaintiffs' suit is simply outside the ambit of the Anti-Injunction Act.[48]

It should also be noted that the Court stated again and again in *Bob Jones* and *"Americans United"* that § 7421 bars *pre-enforcement* injunctions against the assessment and collection of taxes. See e.g. 416 U.S. at 736, 742, 743, 748 n.22. In the instant case, plaintiffs are not seeking a pre-enforcement injunction, since no enforcement—i.e., the assessment and collection of taxes —is about to occur. This in turn means that plaintiffs do not have access to a refund suit or any other means of obtaining judicial review of the legality of IRS action.

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[47] See discussion *supra*, pp. 42-47.

[48] See *McGlotten* v. *Conally*, 338 F. Supp. 448, 453-54 (D.D.C. 1972) where the court held that a challenge by a black American to the granting of tax benefits to a segregated fraternal organization had

> "nothing to do with the assessment or collection of taxes. [Plaintiff] does not contest the amount of his own tax, nor does he seek to limit the amount of tax revenue collectible by the United States. The preferred course of raising his objections in a suit for a refund is not available. In this situation we cannot read the statute to bar the present suit."

The Court expressly pointed out in *Bob Jones University* that "this is not a case in which an aggrieved party has no access at all to judicial review. Were that true our conclusion might well be different." 416 U.S. at 746. Section 7421(a) provides no support, let alone clear and convincing evidence, for the proposition that Congress wished to foreclose all judicial review in cases which do not interrupt the assessment and collection of taxes in any way.

The defendants, perhaps recognizing the weakness of their § 7421 argument, also relied below on the Declaratory Judgment Act, 28 USC § 2201, which excludes suits "with respect to federal taxes." The defendants contended below that the prohibition contained in the Declaratory Judgment Act applies to injunctive relief as well, since a declaration of rights is implicit in an injunction.

Plaintiffs agree that the prohibitions contained in the two Acts are coterminous. It would be incongruous indeed if a court were barred from issuing a declaratory judgment but was free to order injunctive relief.[49] The question then becomes whether the more general language of the Declaratory Judgment Act expands the scope of the Anti-Injunction Act or whether, to the contrary, the language of the Anti-Injunction Act defines the scope of the Declaratory Judgment Act.[50] Legislative history, judicial decisions and common sense all indicate that the Declaratory Judgment Act is governed by the language of the Anti-Injunction Act.

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[49] See *Tomlinson* v. *Smith*, 128 F.2d 808, 811 (7th Cir. 1942):

> "It is unreasonable to think that a court with authority to issue a restraining order is without power to declare the rights of the parties in connection therewith."

[50] This question was specifically left open in *Bob Jones University*, 416 U.S. at 733, n. 7 and *"Americans United,"* 416 U.S. at 752, n. 10.

The legislative history of the Declaratory Judgment Act exclusion demonstrates that it was passed solely to reinforce, rather than expand, the Anti-Injunction Act. The Declaratory Judgment Act was initially passed in 1934, without mention of tax litigation. Some taxpayers immediately began to bring declaratory judgment actions of the kind previously barred by the Anti-Injunction Act.[51] It was this evil which Congress sought to remedy when it enacted the tax exclusion in 1935.

The Senate Report stated:

> Your committee has added an amendment making it clear that the Federal Declaratory Judgments Act of June 14, 1934, has no application to Federal taxes. The application of the Declaratory Judgments Act to taxes would constitute a radical departure from the long-continued policy of Congress (as expressed in [the Anti-Injunction Act] and other provisions) with respect to the determination, assessment, and collection of Federal taxes. Your committee believes that the orderly and prompt determination and collection of federal taxes should not be interfered with by a procedure designed to facilitate the settlement of private controversies, and that *existing procedure both in the Board of Tax Appeals and the courts affords ample remedies for the correction of tax errors.*[52]

Although there is some ambiguous language, the Report plainly indicates that the Congress was not intending to expand the Congressional policy expressed in § 7421. The new provision applied to interference with the collection of taxes, and dealt with those situations in which there were "ample remedies for the correction of tax errors."

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[51] See, *e.g.*, *Penn* v. *Glenn*, 10 F. Supp. 483 (W.D. Ky. 1935), *app. dismissed per curiam*, 84 F.2d 1001 (6th Cir. 1936); *F. G. Vogt and Sons, Inc.* v. *Rothensies*, 11 F. Supp. 225 (E.D. Pa. 1935)

[52] S. Rep. No. 1240, 74th Cong., 1st Sess. 11 (1935).

The courts have never suggested that the declaratory judgment exclusion broadened the scope of the Anti-Injunction Act. Thus, in *Allen* v. *Regents of University System of Georgia*, 304 U.S. 439 (1938) the Supreme Court permitted the Georgia Regents to challenge an excise tax paid by customers of Georgia University football games. The suit was clearly one "with respect to federal taxes." Yet even though plaintiffs specifically sought declaratory as well as injunctive relief, the Court never mentioned the Declaratory Judgment Act or indicated that the Anti-Injunction Act had been altered by Congress in 1935. Similarly, the Supreme Court in *Williams Packing*, *supra*, did not mention the Declaratory Judgment Act, although the exception which the Supreme Court permitted in that case clearly runs afoul of the bar against suits with respect to federal taxes.

In addition, there is a series of circuit court cases in which persons were permitted to sue to protect their property from tax liens levied to satisfy the obligations of other taxpayers. See, *e.g.*, *Bullock* v. *Latham*, 306 F.2d 45 (2d Cir. 1962); *Tomlinson* v. *Smith*, 128 F.2d 808 (7th Cir. 1942); *Rothensies* v. *Ullman*, 110 F.2d 590 (3d Cir. 1940). Although these were cases with respect to federal taxes, the courts did not regard the Declaratory Judgment Act as expanding the scope of the Anti-Injunction Act. Indeed, the courts continued to rely on the leading case of *Long* v. *Rasmussen*, 281 F.236 (9th Cir. 1922) decided years prior to the Declaratory Judgment Act.[53]

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[53] In *Bullock* v. *Latham*, *supra*, the Government argued that plaintiffs' suit had to be "with respect to federal taxes" since it was brought under jurisdictional statutes—28 U.S.C. § 1340 and 28 U.S.C. § 2463—expressly relating to revenue acts of the United States. The Second Circuit rejected the argument out of hand and construed the Declaratory Judgment Act in light of the narrow language of the Anti-Injunction Act.

Any doubt concerning the relationship of the Declaratory Judgment and the Anti-Injunction Acts is resolved by the history of the 1966 amendments to the Anti-Injunction Act.[54] In these amendments, Congress expressly provided for lawsuits in the third party tax lien situation. The Senate Committee Report noted that courts had been providing judicial relief in tax lien situations. It did not disapprove these decisions but stated that they should be "generalized."[55] Although clearly the tax lien suits were suits with respect to federal taxes, the Committee Report never suggested that the suits violated the Anti-Injunction Act.

Congress, after expressly providing for tax lien suits, then amended § 7421(a) to provide that no suit for the assessment or collection of taxes shall be maintained "by any person, whether or not such person is the person against whom such tax was assessed." This additional language is significant in several respects. First, the addition would have been totally unnecessary if the Anti-Injunction Act had already been broadened by the "with respect to federal taxes" language of the Declaratory Judgment Act. Second, the language Congress used—"against whom such tax was *assessed*"—confirms and reemphasizes the narrow scope of § 7421(a). Finally, if Congress had in fact intended the Declaratory Judgment Act to alter the Anti-Injunction Act, it would surely have changed the language of the Anti-Injunction Act at this time to read "with respect to federal taxes."

In sum, the exclusionary clause of the Declaratory Judgment Act does not expand the scope of the Anti-Injunction Act. Neither the Declaratory Judgment Act nor the Anti-Injunction Act are a bar to plaintiffs' lawsuit.

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[54] Federal Tax Lien Act of 1966, Pub. L. 89-719, 80 Stat. 1144.

[55] Sen. Report No. 1708 reprinted in U.S. Code Cong. and Admin. News 3722, 3750 (1966).

B. Plaintiffs' suit falls within a traditional exception to the doctrine of sovereign immunity.

In the courts below, the defendants also attempted to resurrect the widely criticized doctrine of sovereign immunity.[56] In recent decades, the Supreme Court has applied this doctrine in cases involving federal projects, property and contracts.[57] It has not applied the doctrine in cases involving the regulatory activities of federal officials. The decisions of this Court, including several relating directly to taxation, make clear that the instant case is not barred by sovereign immunity.

In *Larson* v. *Domestic and Foreign Commerce Corporation*, 337 U.S. 682 at 689 (1949), this Court reiterated that a suit could be brought against federal officials, without the consent of the United States, to enjoin actions either outside their statutory authority or performed pursuant to an unconstitutional statute.

> . . . where the officer's powers are limited by statute, his actions beyond those limitation are considered individual and not sovereign actions. The official is not doing the business which the sovereign has empowered him to do or he is doing it in a way which the sovereign has forbidden. His actions are ultra vires his authority and therefore may be made the object of specific relief.

See also *Dugan* v. *Rank*, 372 U.S. 609, 621-22 (1963).

In the instant case, plaintiffs allege that defendant federal officials have exceeded their statutory authority under both the Administrative Procedure Act and the

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[56] See, *e.g.*, Jaffe, Judicial Control of Administrative Action 229 (1965); Davis, 3 Administrative Law Treatise, 545-548 (1958).

[57] See *Larson* v. *Domestic and Foreign Commerce Corp.*, 337 U.S. 682 (1949); *Malone* v. *Bowdown*, 369 U.S. 643 (1962); *Dugan* v. *Rank*, 372 U.S. 609 (1963); *City of Fresno* v. *California*, 372 U.S. 627 (1963); *Hawaii* v. *Gordon*, 373 U.S. 57 (1963).

Internal Revenue Code.[58] Thus, unless tax cases are mysteriously different from all other cases, the exception to the doctrine of sovereign immunity applies. And this Court has expressly and implicitly held that the exception to sovereign immunity applies in tax cases.

In *Georgia Railroad & Banking Co.* v. *Redwine*, 342 U.S. 299 (1952), the Court held that a suit brought to enjoin the collection of certain state taxes as violative of the Federal Constitution was not barred by sovereign immunity. Since the doctrine of sovereign immunity is essentially the same for state and federal governments, this case is applicable here. Indeed, the Court cited *Larson* v. *Domestic and Foreign Commerce Corporation*, *supra*, a federal case, both for the proposition that sovereign immunity might apply even though the suit was nominally against a state official and that it did not apply when such official was acting unconstitutionally or beyond the scope of his authority. 342 U.S. at 304 ns.12, 15.

This Court's decision in *Enochs* v. *Williams Packing and Navigation Co.*, *supra*, reaffirmed in *Bob Jones University*, *supra*, and *"Americans United,"* *supra*, also demonstrates that sovereign immunity is not a bar here. In *Williams Packing*, the Court held that, despite the express wording of the anti-injunction provision, plaintiffs could seek to enjoin Treasury's assessment and collection of taxes in certain exceptional circumstances. Since there is no statutory provision for such a suit, it is clearly an unconsented suit against the sovereign. Yet in *Williams Packing*, *Bob Jones* and *"Americans*

[58] The defendants, of course, have statutory authority to issue rulings. But they do not have statutory authority to issue rulings without regard to the procedural requirements of the Administrative Procedure Act and the substantive requirements of the Internal Revenue Code.

United," this Court obviously contemplated that such a suit could be brought.[59]

Indeed, this Court has enjoined the collection and assessment of taxes in a long line of pre-*Williams Packing* cases. See, *e.g.*, *Hill* v. *Wallace*, 259 U.S. 44 (1922); *Lipke* v. *Lederer*, 259 U.S. 557 (1922); *Miller* v. *Standard Nut Margarine Co.*, 284 U.S. 498 (1932); *Allen* v. *Regents of the University System of Georgia*, *supra*. Whatever the present validity of these cases under the Anti-Injunction Act, they certainly stand for the proposition that such suits are not barred by sovereign immunity.

Louisiana v. *McAdoo*, 234 U.S. 627 (1914) is no longer valid. In part that decision appears to rest on an outdated notion of standing; the Court was concerned that a competitor was challenging the tariff rate imposed by the Treasury. 234 U.S. at 631-32. Compare *Association of Data Processing Organizations, Inc.* v. *Camp*, 397 U.S. 150 (1970). To the extent that it holds that a federal official is immune from suit when he exceeds his statutory authority, it has long been overruled.

In sum, the instant case falls comfortably within the traditional exception to the sovereign immunity doctrine. There is thus no necessity for this Court to resolve the conflict among the circuits, discussed below, on the question of whether the Administrative Procedure Act constitutes a waiver of sovereign immunity.

C. The Administrative Procedure Act constitutes a waiver of sovereign immunity.

Section 10(a) of the APA (5 U.S.C. § 702) provides that a "person . . . adversely affected or aggrieved by

[59] In *"Americans United,"* the Government expressly argued that such a suit was barred by sovereign immunity. Brief for the Petitioner, 42-44.

agency action . . . is entitled to judicial review thereof." Federal courts are specifically empowered to "compel agency action unlawfully withheld or unreasonably delayed" and to "hold unlawful and set aside agency action . . . found to be . . . an abuse of discretion, or otherwise not in accordance with law." APA § 10(e), 5 U.S.C. § 706.

On its face, therefore, the APA seems to permit suits against agency officials which might otherwise be shielded by sovereign immunity. The circuits, however, are divided on the question of whether the APA constitutes a waiver of sovereign immunity in actions to which it applies. Three circuits have held that the sovereign immunity of the United States has been waived by the APA.[60] Three circuits have refused to adopt a full-fledged waiver theory, but that nonetheless limited sovereign immunity to exceptional cases.[61] Four circuits have rejected the waiver theory outright.[62]

The Supreme Court in dictum in *Blackmar* v. *Guerre*, 342 U.S. 512, 516 (1952), stated that the APA is not "to be deemed an implied waiver of *all* governmental immunity for suit." (emphasis added). But as Professor Kenneth Davis has responded: "The Act obviously does not waive all governmental immunity from suit; the question was whether it waives such immunity to whatever extent it authorizes judicial review of administrative action." [63]

[60] See *Scanwell Laboratories* v. *Shaffer*, 424 F.2d 859 (D.C. Cir. 1970); *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F.2d 663 (2d Cir. 1973); *Estrada* v. *Ahrens*, 296 F.2d 690 (5th Cir. 1961). But see also *Warner* v. *Cox*, 487 F.2d 1301 (5th Cir. 1974).

[61] See *Schlafly* v. *Volpe*, 495 F.2d 273 (7th Cir. 1974); *Littell* v. *Morton*, 445 F.2d 1207 (4th Cir. 1971); *Washington* v. *Udall*, 417 F.2d 1310 (9th Cir. 1969).

[62] See *Sierra Club* v. *Hickel*, 467 F.2d 1048 (6th Cir. 1972), *cert. denied, sub nom. Sierra Club* v. *Morton*, 411 U.S. 920 (1973); *Motah* v. *United States*, 402 F.2d 1 (10th Cir. 1968); *Twin Cities Chippewa Tribal Council* v. *Minnesota Chippewa Tribe*, 370 F.2d 529 (8th Cir. 1967); *Cyans* v. *United States*, 226 F.2d 416 (1st Cir. 1950).

In its brief in *Train* v. *Campaign Clean Water, Inc.*, 420 U.S. 136 (1975), the Government attempted to brush aside the APA's clear thrust in favor of judicial review by arguing that the Act does not of itself confer jurisdiction. See Brief for Petitioner, pp. 38-39. But several circuits have held that the APA does confer jurisdiction,[64] and Judge Friendly has stated that it is "hard to see how else jurisdiction could have existed" in *Rusk* v. *Cort*, 369 U.S. 367 (1962) and *Flast* v. *Cohen*, 392 U.S. 83 (1968) unless § 10 of the APA constituted an affirmative grant of jurisdiction.[65] More significantly, courts have made clear that Congress may consent to suits against governmental officials in other ways than by enacting a jurisdictional statute. It has been held, for example, that Congress waives sovereign immunity when it includes a "sue and be sued" clause in an agency's statutory charter. See, *e.g.*, *Federal Housing Admin.* v. *Burr*, 309 U.S. 242 (1940); *Pennsylvania* v. *Lynn*, 501 F.2d 848, 851 n.11 (D.C. Cir. 1974). Thus, the APA need not confer jurisdiction in order to constitute a waiver of sovereign immunity.

Plaintiffs contend that the language of section 10 of the APA, like a "sue and be sued" clause, so strongly

[63] Davis, 3 Administrative Law Treatise 585 (1958).

[64] *Pickus* v. *United States Board of Parole*, 507 F.2d 1107 (D.C. Cir. 1974); *Bradley* v. *Weinberger*, 483 F.2d 410 (1st Cir. 1973); *Brandt* v. *Hickel*, 427 F.2d 53 (9th Cir. 1970); *Brennan* v. *Udall*, 379 F.2d 803 (10th Cir. 1967); *Deering Milliken, Inc.* v. *Johnston*, 295 F.2d 856 (4th Cir. 1961). Two circuits have reached contrary decisions: *Zimmerman* v. *United States*, 422 F.2d 326 (3d Cir. 1970), *cert. denied*, 399 U.S. 911 (1970); *Twin Cities Chippewa Tribal Council* v. *Minnesota Chippewa Tribe*, 370 F.2d 529 (8th Cir. 1967).

[65] *Aguayo* v. *Richardson*, 473 F.2d 1090, 1102 (2d Cir. 1973).

presumes reviewability of official action that it must import a waiver of sovereign immunity. They urge the Court to so hold, should the Court deem it necessary to reach the issue.

D. There are no policy justifications for barring review in this case.

Defendants contended below that suits such as plaintiffs' would unduly burden the IRS and the courts. This, of course, is utter nonsense. The number of suits likely to be brought under the jurisdictional approach advanced by plaintiffs is infinitesimal compared to the massive number of refund and tax deficiency suits which the IRS and the courts now confront. Moreover, the substantive issues raised in the few non-taxpayer cases which may be brought are likely, as here, to be no different from the issues raised in refund and tax deficiency suits.[66]

On the other hand, the policy justifications for permitting suits such as plaintiffs' are substantial. Defendants' position means that any IRS tax rulings which result in benefits to taxpayers rather than burdens would be completely immunized from judicial review. Resort to the courts would be barred even in cases involving the most blatantly unconstitutional or illegal conduct.

This Court has often emphasized that the Government faces a heavy burden when it argues against reviewability.[67] The Government clearly has not met that burden here.

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[66] The question of what services hospitals must provide to be considered charitable has been before federal courts for years. See pages 20-24, *supra*.

[67] See, *e.g.*, cases cited in note 44, *supra*.

CONCLUSION

For the foregoing reasons the judgment of the United States Court of Appeals for the District of Columbia Circuit should be reversed and the case remanded.
Date: July 18, 1975

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APPENDIX

APPENDIX

STATUTES AND REGULATIONS

Internal Revenue Code

26 U.S.C. 501

501(a) Exemption from taxation—An organization described in subsection (c) or (d) . . . shall be exempt from taxation under this subtitle . . .

501(c) List of exempt organizations—The following organizations are referred to in subsection (a):

• • • •

(3) Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual. . . .

26 U.S.C. 170

170 Charitable, etc. contributions and gifts—(a) Allowance of deduction (1) General rule. There shall be allowed as a deduction any charitable contribution (as defined in subsection (c)) payment of which is made within the taxable year. . . .

• • • •

(c) Charitable contribution defined. For purposes of this section, the term "charitable contribution" means a contribution or gift to or for the use of—

• • • •

(2) A corporation, trust, or community chest, fund, or foundation—

• • • •

(B) Organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes or for the prevention of cruelty to children or animals;

(C) No part of the net earnings of which inures to the benefit of any private shareholder or individual. . . .

26 U.S.C. 7421

7421 Prohibition of suits to restrain assessment or collection.

(a) Tax—. . . no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed.

Internal Revenue Regulations

26 C.F.R. 1.501(c)(3)-1

1.501(c)(3)-1(d) Exempt purposes—(1) In general. (i) An organization may be exempt as an organization described in section 501(c)(3) if it is organized and operated exclusively for one or more of the following purposes:

(a) Religious,

(b) Charitable,

(c) Scientific,

(d) Testing for public safety,

(e) Literary,

(f) Educational, or

(g) Prevention of cruelty to children or animals.

• • • •

(iii) Since each of the purposes specified in subdivision (1) of this subparagraph is an exempt

purpose in itself, an organization may be exempt if it is organized and operated exclusively for any one or more of such purposes. . . .

1.501(c)(3)-1(d)(2) Charitable defined. The term "charitable" is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions. Such term includes: Relief of the poor and distressed or of the under-privileged; advancement of religion; advancement of education or science; erection or maintenance or public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human and civil rights secured by law; or (iv) to combat community deterioration and juvenile delinquency. The fact that an organization which is organized and operated for the relief of indigent persons may receive voluntary contributions from the persons intended to be relieved will not necessarily prevent such organization from being exempt as an organization organized and operated exclusively for charitable purposes. . . ."

Administrative Procedure Act

5 U.S.C. § 551

553. Rule making

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—

(1) a statement of the time, place, and the nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply—

(A) To interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice;

* * * *

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. . . .

(d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date. . . .

702. Right of review

A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof.

706. Scope of review

. . . The reviewing court shall . . .

(a) hold unlawful and set aside agency action, findings, and conclusions found to be—

(a) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; . . . .

Declaratory Judgment Act

28 U.S.C. 2201

In a case of actual controversy within its jurisdiction, except with respect to Federal taxes, any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought.

REVENUE RULING 56-185

Criteria or tests to be met in determining whether a hospital qualifies for exemption from Federal income tax under section 501(a) of the Internal Revenue Code of 1954 as an organization described in section 501(c)(3) thereof.

Advice has been requested concerning the criteria or tests to be met in determining whether a hospital can qualify for exemption from income tax as a public charitable organization.

Section 501(c) of the Internal Revenue Code of 1954 describes certain organizations exempt from income tax under section 501(a) and reads, in part, as follows:

> (3) Corporations, and any community chest, fund or foundation, organized and operated exclusively for religious, charitable, scientific . . . purposes, . . . and no part of the net earnings of which inures to the benefit of any private shareholder or individual, and no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, and which does not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of any candidate for public office.

The only ground upon which a hospital may be held to be exempt under section 501(c)(3) of the Code is that it is organized and operated primarily for educational, scientific or public charitable purposes. Usually, the ground for exemption is that it is organized and operated for public charitable purposes. The Supreme Court of the United States in *Helvering* v. *Susan D. Bliss et al.*, 293 U.S. 144, Ct. D. 884, C. B. XIII-2, 191 (1934), held that the provisions of law granting exemption of income devoted to charity are liberalizations of the law in the taxpayer's favor, were begotten from motives of public policy, and are not to be narrowly construed. Thus, in regard to hospitals and similar organizations, the Internal Revenue Service takes the position that the term "charitable" in its legal sense and as it is used in section 501(c)(3) of the Code contemplates an implied public trust constituted for some public benefit, the income or beneficial interest of which may not inure to the benefit of any private shareholder or individual.

In order for a hospital to establish that it is exempt as a public charitable organization within the contemplation of section 501(c)(3), it must, among other things, show that it meets the following general requirements:

1. It must be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick. A nonprofit hospital chartered only in general terms as a charitable corporation can meet the test as being organized exclusively for charitable purposes. See *Commissioner* v. *Battle Creek, Inc.* 126 Fed. (2d) 405.

2. It must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that man-

ner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.

3. It must not restrict the use of its facilities to a particular group of physicians and surgeons, such as a medical partnership or association, to the exclusion of all other qualified doctors. Such limitation on the use of hospital facilities is inconsistent with the public service concept inherent in section 501(c)(3) and the prohibition against the inurement of benefits to private shareholders or individuals. It is recognized, however, that in the operation of a hospital there must of necessity be some discretionary authority in the management to approve the qualifications of those applying for the use of the medical facilities. The size and nature of facilities may also make it necessary to impose limitations on the extent to which they may be made available to all reputable and competent physicians in the area.

4. Its net earnings must not inure directly or indirectly to the benefit of any private shareholder or individual. This includes the use by or benefit to its members of its earnings by way of a distribution of profits, the payment of excessive rents or excessive salaries, or the use of its facilities to serve their private interests. If provision is made in the bylaws for dividends, exemption will not be allowed even though no dividends have been declared. Exemption will not be defeated, however, merely be-

cause the shareholders or members might possibly at some future date share in the assets upon dissolution in the absence of a case of mala fides where there appears to be a plan on the part of the shareholder or individual to acquire assets on the dissolution of the corporation.

A community hospital of the type supported partly by contributions from the general public and/or public grants from a city, county or state, normally meets the requirements of section 501(c)(3) as a public charitable organization. It is formed for the purpose of furnishing hospital facilities to all persons in the community at the lowest possible cost and necessarily accepts patients who are unable to pay for hospital facilities in order to retain the support of the community. A nominal charity record for a given period of time, in the absence of charitable demands of the community, will not affect its right to continued exemption. On the other hand, a hospital formed by one or more physicians in a community who may own the capital stock thereof or rent the hospital facilities to a corporation which they control requires careful study to determine whether it is being operated in part to serve their interest, directly or indirectly. See I. T. 2421, C. B. VII-2, 150 (1928).

A hospital formed to operate on a membership basis to provide, at fixed rates, prepaid hospitalization to its members is not a charitable organization within the meaning of section 501(c)(3) of the Code. Compare G. C. M. 22554, C. B. 1941-1, 243. But exemption will not be denied merely because the hospital maintains a prepayment plan, so long as such plan is available to all persons living in the area and so long as the hospital makes available its facilities to indigent as well as to pay patients to the same extent as any other hospital not operated for profit.

A hospital which is organized as required by section 501(c)(3) of the Code, but which engages primarily

in operations foreign to its stated purpose, cannot qualify as a charitable organization under that section. Conversely, a hospital, otherwise exempt, will not lose its exempt status by reason of engaging in operations unrelated to its stated purpose of such operations may be considered as merely incidental. Such a hospital will, however, be required to file an income tax return, Form 990-T, U.S. Exempt Organization Business Income Tax Return, if its gross income (included in computing unrelated business taxable income) for the taxable year is $1,000 or more.

REVENUE RULING 69-545

26 CFR 1.501(c)(3)-1: Organizations organized and operated for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals.

Examples illustrate whether a nonprofit hospital claiming exemption under section 501(c)(3) of the Code is operated to serve a public rather than a private interest; Revenue Ruling 56-185 modified.

Rev. Rul. 69-545 [1]

Advice has been requested whether the two nonprofit hospitals described below qualify for exemption from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954. The articles of organization of both hospitals meet the organizational requirements of section 1.501(c)(3)-1(b) of the Income Tax Regulations, including the limitation of the organizations' purposes to those described in section 501(c)(3) of the Code and the dedication of their assets to such purposes.

Situation 1. Hospital *A* is a 250-bed community hospital. Its board of trustees is composed of prominent citizens in the community. Medical staff privileges in the hospital are available to all qualified physicians in the area, consistent with the size and nature of its facilities. The hospital has 150 doctors on its active staff and 200 doctors on its courtesy staff. It also owns a medical office building on its premises with space for 60 doctors. Any member of its active medical staff has the privilege of leasing available office space. Rents are set at rates comparable to those of other commercial buildings in the area.

The hospital operates a full time emergency room and no one requiring emergency care is denied treatment. The

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[1] Also released as Technical Information Release 1022, dated Oct. 8, 1969.

hospital otherwise ordinarily limits its admissions to those who can pay the cost of their hospitalization, either themselves, or through private health insurance, or with the aid of public programs such as Medicare. Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients.

The hospital usually ends each year with an excess of operating receipts over operating disbursements from its hospital operations. Excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research.

Situation 2. Hospital *B* is a 60-bed general hospital which was originally owned by five doctors. The owners formed a nonprofit organization and sold their interests in the hospital to the organization at fair market value. The board of trustees of the organization consists of five doctors, their accountant, and their lawyer. The five doctors also comprise the hospital's medical committee and thereby control the selection and the admission of other doctors to the medical staff. During its first five years of operations, only four other doctors have been granted staff privileges at the hospital. The applications of a number of qualified doctors in the community have been rejected.

Hospital admission is restricted to patients of doctors holding staff privileges. Patients of the five original physicians have accounted for a large majority of all hospital admissions over the years. The hospital maintains an emergency room, but on a relatively inactive basis, and primarily for the convenience of the patients of the staff doctors. The local ambulance services have been instructed by the hospital to take emergency cases to other hospitals in the area. The hospital follows the policy of

ordinarily limiting admissions to those who can pay the cost of the services rendered. The five doctors comprising the original medical staff have continued to maintain their offices in the hospital since its sale to the nonprofit organization. The rental paid is less than that of comparable office space in the vicinity. No office space is available for any of the other staff members.

Section 501(c)(3) of the Code provides for exemption from Federal income tax of organizations organized and operated exclusively for charitable, scientific, or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual.

Section 1.501(c)(3)-1(d)(1)(ii) of the regulations provides that an organization is not organized or operated exclusively for any purpose set forth in section 501(c)(3) of the Code unless it serves a public rather than a private interest.

Section 1.501(c)(3)-1(d)(2) of the regulations states that the term "charitable" is used in section 501(c)(3) of the Code in its generally accepted legal sense.

To qualify for exemption from Federal income tax under section 501(c)(3) of the Code, a nonprofit hospital must be organized and operated exclusively in furtherance of some purpose considered "charitable" in the generally accepted legal sense of that term, and the hospital may not be operated, directly or indirectly, for the benefit of private interests.

In the general law of charity, the promotion of health is considered to be a charitable purpose. *Restatement (Second), Trusts*, sec. 368 and sec. 372; IV *Scott on Trusts* (3rd ed. 1967), sec. 368 and sec. 372. A nonprofit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a

charitable purpose. If it meets the other requirements of section 501(c)(3) of the Code, it will qualify for exemption from Federal income tax under section 501 (a).

Since the purpose and activity of Hospital *A*, apart from its related educational and research activities and purposes, are providing hospital care on a nonprofit basis for members of its community, it is organized and operated in furtherance of a purpose considered "charitable" in the generally accepted legal sense of that term. The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community. *Restatement (Second), Trusts*, sec. 368, comment (b) and sec. 372, comments (b) and (c); IV *Scott on Trusts* (3rd ed. 1967), sec. 368 and sec. 372.2. By operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, Hospital *A* is promoting the health of a class of persons that is broad enough to benefit the community.

The fact that Hospital *A* operates at an annual surplus of receipts over disbursements does not preclude its exemption. By using its surplus funds to improve the quality of patient care, expand its facilities, and advance its medical training, education, and research programs, the hospital is operating in furtherance of its exempt purposes.

Furthermore, Hospital *A* is operated to serve a public rather than a private interest. Control of the hospital

rests with its board of trustees, which is composed of independent civic leaders. The hospital maintains an open medical staff, with privileges available to all qualified physicians. Members of its active medical staff have the privilege of leasing available space in its medical building. (See Rev. Rul. 69-464, page 132, this Bulletin.) It operates an active and generally accessible emergency room. These factors indicate that the use and control of Hospital *A* are for the benefit of the public and that no part of the income of the organization is inuring to the benefit of any private individual nor is any private interest being served.

Accordingly, it is held that Hospital *A* is exempt from Federal income tax under section 501(c)(3) of the Code.

Hospital *B* is also providing hospital care. However, in order to qualify under section 501(c)(3) of the Code, an organization must be organized and operated *exclusively* for one or more of the purposes set forth in that section. Hospital *B* was initially established as a proprietary institution operated for the benefit of its owners. Although its ownership has been transferred to a nonprofit organization, the hospital has continued to operate for the private benefit of its original owners who exercise control over the hospital through the board of trustees and the medical committee. They have used their control to restrict the number of doctors admitted to the medical staff, to enter into favorable rental agreements with the hospital, and to limit emergency room care and hospital admission substantially to their own patients. These facts indicate that the hospital is operated for the private benefit of its original owners, rather than for the exclusive benefit of the public. See *Sonora Community Hospital* v. *Commissioner*, 46 T.C. 519 (1966), aff'd. 397 F. 2d 814 (1968).

Accordingly, it is held that Hospital *B* does not qualify for exemption from Federal income tax under section

501(c)(3) of the Code. In considering whether a nonprofit hospital claiming such exemption is operated to serve a private benefit, the Service will weigh all of the relevant facts and circumstances in each case. The absence of particular factors set forth above or the presence of other factors will not necessarily be determinative.

Even though an organization considers itself within the scope of *Situation* 1 of this Revenue Ruling, it must file an application on Form 1023, Exemption Application, in order to be recognized by the Service as exempt under section 501(c)(3) of the Code. The application should be filed with the District Director of Internal Revenue for the district in which is located the principal place of business or principal office of the organization. See section 1.501(a)-1 of the regulations.

Revenue Ruling 56-185, C.B. 1956-1, 202, sets forth requirements for exemption of hospitals under section 501(c)(3) more restrictive than those contained in this Revenue Ruling with respect to caring for patients without charge or at rates below cost. In addition, the fourth requirement of Revenue Ruling 56-185 is ambiguous in that it can be read as implying that the possibility of "shareholders" or "members" sharing in the assets of a hospital upon its dissolution will not preclude exemption of the hospital as a charity described in section 501(c)(3) of the Code. Section 1.501(c)(3)-1(b)(4) of the regulations promulgated subsequent to Revenue Ruling 56-185 makes it clear, however, that an absolute dedication of assets to charity is a precondition to exemption under section 501(c)(3) of the Code.

Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost. Furthermore, requirement four has been modified by section 1.501(c)(3)-1(b)(4) of the regulations.

CHART

Sample of Medium-Sized Communities Not Served by Public Hospitals

STATE	CITY [1] (POP.)	COUNTY [1] (POP.)	GENERAL HOSPITALS [2] IN COUNTY
Alabama	Selma (27,379)	Dallas (55,296)	3 Nonprofit
Arizona	Flagstaff (26,117)	Coconino (48,326)	1 Nonprofit
Arizona	Yuma (29,007)	Yuma (60,827)	1 Nonprofit 2 Federal
Arkansas	Pine Bluff (57,389)	Jefferson (85,329)	1 Nonprofit
Delaware	Wilmington (80,836)	New Castle (385,856)	3 Nonprofit
Florida	Orlando (99,006)	Orange (344,311)	6 Nonprofit 1 Public (Winter Park, Fla.)
Idaho	Idaho Falls (35,776)	Bonneville (52,457)	2 Nonprofit
Illinois	Bloomington (39,992)	McLean (104,389)	3 Nonprofit
Illinois	Peoria (126,963)	Peoria (195,318)	3 Nonprofit
Indiana	Evansville (138,764)	Vanderburgh (168,722)	3 Nonprofit
Indiana	Terre Haute (70,335)	Vigo (114,528)	2 Nonprofit
Iowa	Waterloo (75,533)	Blackhawk (132,916)	3 Nonprofit 1 Public (Cedar Falls, Ia.)
Kansas	Tokepa (125,011)	Shawnee (155,322)	3 Nonprofit
Mass.	Pittsfield (57,020)	Berkshire (149,402)	3 Nonprofit

STATE	CITY [1] (POP.)	COUNTY [1] (POP.)	GENERAL HOSPITALS [2] IN COUNTY
Michigan	Bay City (49,449)	Bay (117,339)	3 Nonprofit
Minnesota	Duluth (100,578)	St. Louis (220,693)	8 Nonprofit 1 Public (Virginia, Minn.)
Missouri	Springfield (120,096)	Greene (152,929)	4 Nonprofit
North Carolina	Asheville (57,681)	Buncombe (145,056)	3 Nonprofit 1 Federal
North Carolina	Charlotte (241,178)	Mecklenburg (354,656)	3 Nonprofit
Virginia	Alexandria (110,938)	none (indep. city)	3 Nonprofit
Virginia	Arlington (174,284)	Arlington (174,284)	2 Nonprofit
Virginia	Falls Church (10,772)	none (indep. city)	1 Nonprofit
Virginia	Fairfax (21,970)	none (indep. city)	1 Nonprofit
Washington	Spokane (170,516)	Spokane (287,487)	6 Nonprofit 2 Federal

[1] Population data are 1970 census figures from Rand McNally Premier World Atlas (1970 ed).

[2] Hospital data are from American Hospital Ass'n Guide to Health Care Field (1974 ed.). Note that the Federal Hospitals are either military, veteran or Indian facilities and therefore serve a limited sector of the community.

Supreme Court, U. S.
FILED
SEP 22 1975
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Nos. 74-1110 and 74-1124

In the Supreme Court of the United States

OCTOBER TERM, 1975

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL., PETITIONERS
v.
WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL., PETITIONERS
v.
EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE SECRETARY OF THE TREASURY, ET AL.

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In the Supreme Court of the United States

OCTOBER TERM, 1975

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL., PETITIONERS

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.

No. 74-1124

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL., PETITIONERS

v.

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE SECRETARY OF THE TREASURY, ET AL.

OPINIONS BELOW

The opinion of the district court (Pet. App. A 1A-26A)[1] is reported at 370 F. Supp. 325. The opinion of the court of appeals (Pet. App. B 31A-57A) is reported at 506 F.2d 1278.

JURISDICTION

The judgment of the court of appeals was entered on October 9, 1974 (Pet. App. C 59A-60A). On December 6, 1974, the court denied a petition for rehearing by Eastern Kentucky Welfare Rights Organization, and also denied its suggestion of rehearing *en banc*, with three dissents (Pet. App. D 61A-67A). On December 30, 1974, the Chief Justice extended the time for the Secretary of the Treasury to file a petition for a writ of certiorari to and including March 8, 1975. Eastern Kentucky's petition (No. 74-1110) was filed on March 6, 1975. The Secretary of the Treasury's petition (No. 74-1124) was filed on March 8, 1975. Both petitions were granted and the cases consolidated on May 19, 1975 (A. 176-177). The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

QUESTIONS PRESENTED

No. 74-1124. Whether the federal courts may review the correctness of Revenue Rulings and other similar administrative determinations made by the

[1] "Pet. App." refers to the petition for a writ of certiorari filed on behalf of William E. Simon, Secretary of the Treasury, *et al.*, in No. 74-1124.

Department of the Treasury, in equity suits brought by persons whose own tax liabilities are not at issue.

If the foregoing question is answered affirmatively, there are two additional questions presented in No. 74-1110:

1. Whether a Revenue Ruling issued by the Secretary of the Treasury—providing that a hospital is entitled to tax exemption if it furnishes emergency care for all persons regardless of their ability to pay but otherwise ordinarily limits admission to those who can pay their hospitalization costs, either themselves, through private health insurance, or with the aid of public programs such as Medicare—correctly interprets Section 501(c)(3) of the Internal Revenue Code of 1954, which accords tax-exempt status to organizations organized and operated exclusively for "charitable" purposes.

2. Whether the Secretary's promulgation of the Revenue Ruling was exempt from the notice and hearing requirements of the Administrative Procedure Act, 5 U.S.C. 553, because the Ruling was an "interpretative rule."

STATUTES AND REGULATIONS INVOLVED

The relevant provisions of Sections 170(c)(2)(B), 501(c)(3), 7801 and 7802 of the Internal Revenue Code of 1954, 26 U.S.C., the Declaratory Judgment Act, 28 U.S.C. 2201 and 2202, the Administrative

Procedure Act, 5 U.S.C. 553(b)(3) and (c), and Treasury Regulations on Income Tax (1954 Code), Section 1.501(c)(3)-1(d)(2) are set forth in Appendix A, *infra*, pp. 1a-5a.

STATEMENT

1. This class action was brought in the United States District Court for the District of Columbia by a number of national and regional nonprofit health and welfare organizations and several individuals on behalf of all persons who are unable to pay for the costs of hospital care. The complaint alleged that the Secretary of the Treasury and the Commissioner of Internal Revenue erroneously recognized as tax exempt under Section 501(c)(3) of the Internal Revenue Code of 1954, private, nonprofit hospitals that do not render a complete range of free or below-cost service to indigents (A. 25-29).

Petitioners [2] sought broad declaratory and injunctive relief "declaring the rights of poor people to receive services without charge from private hospitals which receive federal tax exemptions as 'charitable' institutions under 28 [*sic*] U.S.C. 501(c)(3), and restraining and enjoining [the Treasury officials] from granting or continuing to grant tax exemptions to private hospitals which refuse admis-

[2] "Petitioners" refers to Eastern Kentucky Welfare Rights Organization, *et al.*, the plaintiffs in the district court and petitioners in No. 74-1110. Respondents in No. 74-1110 and petitioners in No. 74-1124, William E. Simon, Secretary of the Treasury, *et al.*, will be referred to as "the Treasury" or "the Treasury officials."

sion and free services to persons unable to pay * * *" (A. 10). Petitioners also sought an injunction requiring the Treasury to withdraw the eligibility of such hospitals for rulings recognizing their tax-exempt status under Section 501(c)(3) of the Code, and the deductibility of contributions to them under Section 170(c)(2), 26 U.S.C. (*ibid.*).

2. This suit resulted from the publication by the Commissioner of Internal Revenue on November 3, 1969, of Rev. Rul. 69-545, 1969-2 Cum. Bull. 117, Appendix B, *infra*, pp. 6a-18a, which sets forth the Internal Revenue Service's position with regard to the exempt status of nonprofit hospitals. This Revenue Ruling stated the conclusions of the Internal Revenue Service as to whether nonprofit hospitals, designated Hospital *A* and Hospital *B*,[3] qualified for

[3] Revenue Rulings characteristically refer to taxpayers in this manner to preserve anonymity. They also adopt other conventions to avoid identification of the taxpayer or taxpayers who may have been the recipients of private letter rulings on which the Revenue Rulings were based. Each issue of the Internal Revenue Bulletin and each volume of the Cumulative Bulletin contains in its Introduction a statement identical with, or similar to, the statement that appeared in the Introduction to 1969-2 Cum. Bull. xxii: "Revenue Rulings represent the conclusions of the Service on the application of the law to the entire state of facts involved. In those that are based on positions taken in rulings to taxpayers or technical advice to service field offices, identifying details and confidential information are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements, such as 18 U.S.C. 1905 and 26 U.S.C. 7213 concerning disclosure of information obtained from members of the public."

exemption from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1954.

The facts set forth in the Ruling with respect to Hospital *A* were as follows: It was controlled by a board of trustees composed of independent civic leaders. It maintained an open medical staff, with staff privileges available to all qualified physicians. Staff physicians could lease office space at the hospital office building at rates comparable to commercial rates in the area.

Hospital *A* operated a full-time emergency room, and no one requiring emergency care was denied treatment regardless of ability to pay. Otherwise, it ordinarily limited its admissions to those who could pay the cost of their hospitalization, either themselves, or through private health insurance, or with the aid of public programs such as Medicare. However, patients who could not meet the financial requirements for admission were ordinarily referred to another hospital in the community that did serve indigent patients.

On these facts, the Service concluded that the purpose and activity of Hospital *A*, apart from its related educational and research purposes and activities, were to provide hospital care, and thus the promotion of health, on a nonprofit basis for members of its community. The Revenue Ruling held, therefore, that Hospital *A* was organized and operated in furtherance of a purpose considered to be "charitable" so as to be exempt from federal income tax under Section 501(c)(3) of the Code.

The facts concerning Hospital *B*, the other hospital considered in the Ruling, were as follows: It had originally been owned by five doctors. The doctors formed a nonprofit organization and sold their interests in the hospital to the organization at fair market value. The board of trustees of the nonprofit organization consisted of the five doctors, their accountant and their lawyer. The five doctors also comprised the hospital's medical committee, which controlled admission of other doctors to the medical staff. In five years of operation of the hospital by the nonprofit organization, the medical committee granted staff privileges to only four other doctors and had rejected applications of a number of qualified doctors in the community.

Hospital *B* restricted admission to patients of the doctors holding staff privileges, and ordinarily to those who could pay the cost of services rendered. Patients of the five original doctor-owners accounted for a large majority of hospital admissions over the years. Those five doctors continued to maintain their offices in the hospital, and paid rent which was less than commercial rates for comparable quarters. No office space was made available for any other staff member. The hospital maintained an emergency room, but on a relatively inactive basis, and primarily for the convenience of the staff doctors' patients. Hospital *B* had instructed local ambulance services to take emergency cases to other hospitals in the area.

On these facts, the Revenue Ruling held that Hospital *B* was operated for private benefit and, accordingly, did not qualify for exemption from federal income tax under Section 501(c)(3) of the Code.

In concluding that Hospital *A* qualified for exemption, Rev. Rul. 69-545 modified in part the requirements that had been previously published as Rev. Rul. 56-185, 1956-1 Cum. Bull. 202, Appendix B, *infra*, pp. 13a-18a. In the earlier Ruling, the Internal Revenue Service concluded that for a hospital to qualify for exemption (*id.* at 203):

> It must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services.

3. In this action, petitioners alleged that Rev. Rul. 69-545 was an erroneous interpretation of Section 501(c)(3), and that the Commissioner's issuance of the Ruling had resulted in their inability to receive medical care from tax-exempt hospitals by "encouraging such hospitals to deny their services to individual PLAINTIFFS and the class to which they belong

* * *" (A. 25). They further alleged that the Ruling was void because it had not been issued in accordance with the rule-making provisions of the Administrative Procedure Act, 5 U.S.C. 553, requiring a public hearing and an opportunity for interested and affected persons to be heard (A. 26). Accordingly, petitioners requested a judicial declaration that the Treasury officials had acted unlawfully in recognizing the tax-exempt status of private hospitals that did not admit and provide free or below-cost medical care to indigents (A. 25-26).

Petitioners also sought an injunction requiring the Commissioner of Internal Revenue to revoke his recognition of the tax-exempt status of hospitals that did not serve persons unable to pay or those covered by Medicaid and to collect all taxes due from such hospitals (A. 27-28). Petitioners further requested an injunctive order against the Commissioner that all private hospitals which desired to attain or retain recognition as tax exempt be required "to file specific data, on forms devised by the DEFENDANTS * * *, and approved by this Court, * * * verifying that [such] hospitals do afford service to persons unable to pay, do not discriminate against * * * Medicaid [patients], do not require a deposit as a condition for admission * * *, and do not attempt to collect payment for persons determined to be too poor to pay for services" (A. 28). Finally, petitioners requested a declaration that the Commissioner lacked the legal authority to issue Rev. Rul. 69-545, which recognized the tax-exempt status

of hospitals which do not provide non-emergency treatment to persons unable to pay the costs, either themselves or through private health insurance or Medicare (A. 29).

4. The Treasury officials moved to dismiss the complaint on the ground that the court lacked jurisdiction (A. 31-32). The district court denied the motion to dismiss without opinion (A. 33). Subsequently, upon the parties' cross-motions for summary judgment, the district court granted summary judgment for petitioners. It held that the court had jurisdiction to determine whether Rev. Rul. 69-545 was erroneous and that petitioners had standing to maintain the action. The court further held that the Revenue Ruling was invalid. In view of that holding, the court did not reach petitioners' contention that the Ruling was void because it was not issued in accordance with the notice and hearing provisions of the Administrative Procedure Act (Pet. App. A 1A-26A).

The district court substantially granted the declaratory and injunctive relief requested by petitioners. It declared that Rev. Rul. 69-545 was void to the extent it modified the prior Ruling with respect to the requirement that hospitals provide care for patients without charge or at below-cost rates. The court thereupon enjoined the Treasury officials from recognizing the tax-exempt status of private hospitals unless they: (1) were operated, to the extent of their financial ability, for those not able to pay for services; (2) furnish such "charitable" services on

a below-cost or no-charge basis; (3) did not refuse patients in need of hospital care who cannot pay.

In addition, the court ordered the Treasury officials to prepare notices subject to the approval of the court, and required exempt hospitals or applicants for exemption to post such notices, which would state that exemption had been applied for or granted and explain the free or below-cost requirement of the prior Rev. Rul. 56-185. Finally, the court ordered the Treasury officials to "take the necessary and immediate steps to implement this Order, including * * * revoking the voided portion of Revenue Ruling 69-545 and promulgating in its stead appropriate Rulings," and also to "report their progress to the Court within 60 days * * *" (Pet. App. A 27A-29A).[4]

Pursuant to the district court's direction, on April 1, 1974, the Treasury officials submitted a report to

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[4] On February 6, 1974, the government moved in the district court for a stay of the injunctive provisions of the order pending appeal because of the broad adverse impact upon the administration of the exempt organization tax provisions. On February 21, 1974, the district court denied the motion without opinion (A. 6).

Five days later, the government sought a stay of injunctive relief from the court of appeals. In support of the application, the government filed a supplemental memorandum in which it advised the court that the indefinite status of Rev. Rul. 69-545 was delaying and impeding the orderly issuance of letter rulings to hospitals, and in several instances had jeopardized municipal bond issues for hospital purposes. On March 26, 1974, the court of appeals denied the motion for a stay and placed the case on an accelerated briefing and argument schedule (A. 170-171).

that court of the progress in implementing its order. Appendix C, *infra*, pp. 19a-30a. The report included a proposed Revenue Ruling and Revenue Procedure which were designed to carry out the injunctive order. On April 10, 1974, petitioners filed a memorandum opposing the Treasury officials' compliance program. Their opposition requested, *inter alia*, that the court order the Treasury officials to revise the exemption ruling application form and to require hospitals to furnish more detailed information annually to the Internal Revenue Service. Appendix D, *infra*, pp. 31a-37a. However, the district court has never acted upon either the Treasury officials' progress report or petitioners' opposition with respect to the nature or timing of the requested relief.

5. The court of appeals sustained the district court's holding with respect to jurisdiction. It concluded that the federal courts may review the correctness of Revenue Rulings and other similar administrative determinations made by the Department of the Treasury and grant equitable relief to persons whose own tax liabilities are not at issue (Pet. App. B 36A-43A).

However, a divided court of appeals reversed the judgment of the district court with respect to the merits of petitioners' claim. It held that Rev. Rul. 69-545 was not inconsistent with the legislative intent of Section 501(c)(3) and that the Treasury's modification of its prior Revenue Ruling was proper. The court of appeals also held that the Revenue Ruling was interpretative, so that it was not subject

to the notice and hearing provisions of the Administrative Procedure Act, and that promulgation of the Ruling did not constitute an abuse of discretion (Pet. App. B 45A-56A).

SUMMARY OF ARGUMENT

I

A

1. In 1969, the Commissioner of Internal Revenue published Rev. Rul. 69-545, which sets forth the Internal Revenue Service's position with regard to the exempt status of nonprofit hospitals. The Ruling concluded that a hospital is entitled to tax exemption if it furnishes emergency care for all persons, regardless of their ability to pay, but otherwise limits admission to those who can pay their hospital admission costs, either themselves, through private health insurance, or with the aid of public programs such as Medicare. This Ruling modified an earlier Ruling which had concluded that a tax-exempt hospital must be operated to the extent of its financial ability for those not able to pay.

Acting on behalf of all persons unable to pay for the costs of hospital care, petitioners brought this action seeking restoration and enforcement of the previously outstanding Ruling with respect to the tax-exempt status of private hospitals. In so doing, petitioners hope, through the mechanism of this suit, to effect a change in what they perceive as the present hospital policies governing the extent to which pri-

vate hospitals furnish medical care for the indigent. Petitioners thus seek to use the Internal Revenue laws to effect a broad transformation in the social structure.

2. The federal courts have no jurisdiction to entertain a suit challenging the Treasury's tax treatment of third parties brought by persons whose own tax liabilities are not at issue. In the context of this case, where petitioners seek to compel the revocation of a published Revenue Ruling, the continued effectiveness of the Treasury's entire rulings program is at stake. Under this program, the Internal Revenue Service issues each year approximately 40,000 advance letter rulings setting forth its opinion concerning the federal tax consequences of specific proposed transactions. From the thousands of letter rulings it issues each year, the Service selects and edits several hundred for publication in its Bulletin in more abstract and anonymous form as Revenue Rulings. The aim of this publication program is to inform subordinate officials, taxpayers and their representatives of the established policies of the Internal Revenue Service.

Thus, the published Revenue Rulings and letter rulings programs instruct the public with respect to the application of the technical provisions of the Internal Revenue Code, contribute in large measure to uniformity of interpretation of the tax law and thereby enhance public compliance with the revenue statutes. Moreover, by establishing a reliable procedure for the dissemination of advance information, the

Revenue Rulings program promotes the stability of our self-reporting tax system by reducing controversies and litigation. In this respect, the Internal Revenue Service is unique. No other agency of the federal government maintains such an ambitious and wide-ranging program of making known its current interpretative opinions respecting the statute it administers.

By concluding that the courts are empowered to exercise review authority over published Revenue Rulings in equity suits brought by persons whose own tax liabilities are not at issue, the jurisdictional holding of the court of appeals discourages the Internal Revenue Service from making public its views on questions arising under the tax statutes. It invites anyone who disagrees with a letter ruling or a published Revenue Ruling to sue the responsible Treasury officials to enjoin them from taking any action consistent with the Ruling. Moreover, in holding that a Revenue Ruling can be judicially revoked retroactively simply on the basis of another view of the law, the decision below has impaired the element of reliance inherent in the rulings system and thereby has greatly reduced the effectiveness of this program of tax administration. If the federal courts could generally order the retroactive revocation of a Revenue Ruling at the behest of persons whose own tax liabilities are not at issue, the elimination of predictability of result would unquestionably increase the number of controversies and litigated cases, thereby multiplying the burdens upon the courts.

3. The present Internal Revenue Code and its predecessor Revenue Acts reveal a consistent congressional intent to vest the administration of the tax laws exclusively in the Department of the Treasury. From the very inception of the Treasury as the tax-collecting arm of the federal government, Congress has vested in its officials broad discretion in the enforcement of the revenue laws. An early taxing statute enacted in 1792 directed the Secretary of the Treasury to administer the revenue laws "as he shall judge best." Similarly, the current statutory provisions cast the authority of the Secretary of the Treasury and the Commissioner of Internal Revenue in the broadest possible terms, and include the power to prescribe all needful rules, make assessments, bring suits for the collection of taxes, make refunds, and compromise both civil and criminal cases.

For example, Section 6406 of the Code provides that the findings of fact and decisions on the merits of the Secretary or his delegate in allowing claims for refund shall not be subject to review by any other federal administrative or accounting officer. Pursuant to the predecessor of this statutory directive, this Court long ago repeatedly held that no other officer of the federal government may sue to recover a refund allowed by the Commissioner of Internal Revenue within the exercise of his exclusive jurisdiction over the administration of the tax laws. The proposition that private parties, such as petitioners, should not be able to set aside the decision of the

Commissioner not to tax a particular group of hospitals follows *a fortiori* from these decisions.

4. The broad authority that Congress has given the Secretary of the Treasury and the Commissioner of Internal Revenue over the administration of the tax laws shows that it intended to vest the administration of the revenue laws exclusively in the Executive Branch and did not intend the courts to entertain suits of this kind. If one person could bring an action against the Treasury objecting to the tax treatment accorded another person, the courts would quickly be drawn into performing the tax administration function reserved to the Executive Branch. Indeed, if petitioners can maintain this action, there are many others who could utilize litigation with the Internal Revenue Service as a sword to be wielded against adversaries. For example, such litigation might be brought to compel the Service to audit a particular taxpayer according to standards that the plaintiffs insisted were required by the statute rather than those employed by the Service. The institution of such suits would require the Treasury to channel its energies in the pursuit of questions deemed important not by it but by a host of private plaintiffs who claim to assert the public interest but who have no ultimate responsibility for tax administration.

Thus, in *Louisiana* v. *McAdoo*, 234 U.S. 627, the Court dismissed a similar suit by the State of Louisiana, itself a producer of sugar, seeking an order compelling the Secretary of the Treasury to collect higher duties on imported sugar. It observed that

the maintenance of such actions "would operate to disturb the whole revenue system of the Government" and that "[i]nterference [by the courts] in such a case would be to interfere with the ordinary functions of government" (234 U.S. at 632, 633). The same reasoning applies here.

B

1. The impropriety of the entertainment by the courts below of petitioners' challenge to the Commissioner's Revenue Ruling is also shown by their lack of standing to maintain such an action. This result is indicated by *Linda R.S.* v. *Richard D.*, 410 U.S. 614, which held that the plaintiff, the mother of an illegitimate child, had no standing to maintain an action to enjoin the "discriminatory application" of a state statute which provided a criminal penalty for the failure of a father to support his children, based upon the claim that the district attorney refused to take action because, in his view, the fathers of illegitimate children were not within the scope of the statute. The Court ruled that "a private citizen lacks a judicially cognizable interest in the prosecution or nonprosecution of another" (410 U.S. at 619).

The principle of *Linda R.S.* is fully applicable here and requires dismissal of this suit. Just as the plaintiff in *Linda R.S.* had no standing to contest the prosecution of the father of her child, petitioners here have no standing to challenge the Treasury's decision not to tax certain hospitals described in

Rev. Rul. 69-545. There is no meaningful difference between the Secretary of the Treasury's role in enforcement of the Internal Revenue Code and the role of other prosecutors whose judgment has remained free from judicial control.

2. Moreover, here, as in *Linda R.S.*, the likelihood that a ruling in the plaintiff's favor would ultimately provide the relief sought could "at best, be termed only speculative" (410 U.S. at 618). Petitioners have not shown that the change in the tax-exempt status of hospitals which petitioners seek to accomplish by their attack on the Revenue Ruling would result in the provision of medical care for the indigent. Like the father of the illegitimate child who may prefer to go to jail rather than pay support, a hospital might well elect to forego its tax-exempt status. This is especially true in light of the fact that private philanthropy has declined to only about 4 percent of the revenue of private hospitals.

C

This suit is also barred by the Anti-Injunction and the Declaratory Judgment Acts. The former provision states that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person * * *." The Declaratory Judgment Act bars any declaratory suit "with respect to Federal taxes."

1. The court of appeals held that the bar of the Anti-Injunction Act was not applicable to this case because petitioners do not seek to restrain the "assessment or collection" of any tax, but rather seek to in-

crease the amount of taxes which would be paid by any hospital which does not provide a full range of medical services for the indigent. But this ruling ignores this Court's statement in *State Railroad Tax Cases*, 92 U.S. 575, 613, that the Act was intended to prevent judicial interference "with the *process* of collecting the taxes on which the government depends for its continued existence" (emphasis supplied). The "process" of tax collection by the Department of the Treasury includes the making of administrative determinations such as the Revenue Ruling at issue here. Moreover, the word "restrain" in the Anti-Injunction Act does not necessarily limit the Act's application to those suits seeking to "lower" or "reduce" tax collections, since that word means "to limit or restrict * * * a particular action or course." Since petitioners seek to limit the Commissioner's policy regarding the tax-exempt status of hospitals to the test promulgated in the prior Revenue Ruling, they do in fact seek to "restrain" the process of assessment and collection of taxes within the meaning of the Anti-Injunction Act.

2. Even assuming, *arguendo*, that the Anti-Injunction Act does not bar this suit, petitioners' attempt to obtain a judicial declaration with respect to the tax liabilities of various hospitals and their contributors falls within the broader statutory prohibition of the Declaratory Judgment Act which bars any declaratory suit "with respect to Federal taxes." The conclusion of the court of appeals that the Declaratory Judgment Act is "coterminous" with the Anti-

Injunction Act fails to take account of the words of that statute and its legislative history and misreads the applicable precedents. The decisions of the lower federal courts have applied the Declaratory Judgment Act prohibitions to analogous nontaxpayer suits respecting the federal tax liabilities of other parties.

D

Petitioners' complaint should have been dismissed for the additional reason that it is an unconsented suit against the United States and is barred by sovereign immunity. A suit is against the sovereign if "the judgment sought would expend itself on the public treasury or domain, or interfere with the public administration," *Land* v. *Dollar*, 330 U.S. 731, 738, or if the effect of the judgment would be "to restrain the Government from acting, or to compel it to act," *Larson* v. *Domestic & Foreign Corp.*, 337 U.S. 682, 704. Although the named defendants in this suit are the Secretary of the Treasury and the Commissioner of Internal Revenue, petitioners are not suing them in their individual capacities but are seeking to require them to perform certain actions in their official capacities as administrators of the federal tax laws. Thus, the suit is against the sovereign under the standard of *Hawaii* v. *Gordon*, 373 U.S. 57, because "the order requested would require the * * * [Secretary's] official affirmative action, [and] affect the public administration of government agencies" (*id.* at 58).

The court of appeals erroneously concluded that sovereign immunity did not bar this action because: (a) petitioners were challenging the authority of the

Commissioner of Internal Revenue to interpret a revenue statute in a manner contrary to established congressional policy, and (b) the Administrative Procedure Act constitutes a waiver of sovereign immunity.

(a) In *Larson* v. *Domestic & Foreign Corp.*, *supra*, this Court recognized that suits against officers are not suits against the sovereign if the officer allegedly has acted beyond his statutory powers or if the statute under which he acts is alleged to be unconstitutional. Neither exception is applicable to this case. Petitioners do not complain that the Secretary or the Commissioner acted unconstitutionally or beyond their statutory powers, but only that the Commissioner has made an erroneous interpretation of the term "charitable" in Section 501(c)(3) of the Code. Accordingly, this case falls within the well-established rule that an Executive official's performance of a statutory duty to interpret the law is an action of the sovereign which the courts may not enjoin unless Congress has consented to such a suit.

(b) The second reason of the court of appeals—that the viability of the sovereign immunity doctrine is open to question after the enactment of the Administrative Procedure Act in 1946—is also incorrect. The Administrative Procedure Act does not waive the United States' sovereign immunity, and six courts of appeals have so held. Although three circuits, including the court below, have taken the contrary view, those decisions cannot be squared with the statement of this Court in *Blackmar* v. *Guerre*, 343 U.S. 512, 515-516, that "[s]till less is the [Administrative Procedure] Act to be deemed an implied waiver of all governmental immunity from suit."

If the Court agrees with the foregoing submission, that is the end of the matter and the judgment of the court of appeals should be reversed and the case remanded to the district court with directions to dismiss the complaint for lack of jurisdiction. If, however, the Court disagrees with our jurisdictional argument, it will then have to consider the questions presented in No. 74-1110, which are discussed below in Points II and III.

II

1. The Secretary's Revenue Ruling that a hospital is entitled to exemption from income taxes if it furnishes emergency care for all persons regardless of their ability to pay correctly interprets the term "charitable" in Section 501(c)(3) of the Internal Revenue Code. This exemption for "charitable" organizations antedates the enactment of the modern income tax. At no time, however, did Congress attempt precisely to define "charitable" but left the compass of that statutory term for the Secretary of the Treasury to define in his administration of the tax laws.

As the court of appeals correctly noted, it is well established that the term "charitable" may be defined more broadly than merely relief of the poor. Although the Treasury Regulations under the 1939 Code predecessor provision of Section 501(c)(3) specified "relief of the poor" as the applicable charitable

requirement, the current Regulations, which were adopted in 1959 after hearing, expanded that definition to provide that the term "charitable" must be used in its generally accepted legal sense, which is not limited to its popular meaning of benevolence to the poor. See *Green* v. *Connally*, 330 F. Supp. 1150, 1159 (D. D.C.), affirmed *per curiam sub nom. Coit* v. *Green*, 404 U.S. 997.

The evolution of the "charitable" concept in the law of trusts and the Regulations' reference to the meaning of "charitable" in its accepted legal sense demonstrates the correctness of Rev. Rul. 69-545. While certain early charitable trust cases required charitable hospitals to accept all patients regardless of their ability to pay, most recent trust cases involving hospitals recognize that in certain circumstances the promotion of health is a charitable purpose, separate and apart from any requirement of free service to the poor.

The evolution of the tax law has proceeded along similar lines. While service to the poor was given more emphasis in the Treasury's initial administration of the charitable standard, several early decisions upheld tax-exempt status on a broader concept of the term "charitable." The 1959 Regulations were a formal recognition by the Treasury that free care for the indigent would no longer be given exclusive emphasis.

2. There are sound reasons underlying the Commissioner's modification of his Ruling on hospitals. Unlike the situation early in our nation's history, when the hospital as an institution was an alms-

house for the poor supported by private philanthropy, the hospital today is the primary community health facility for rich and poor alike. Since 1953, when the Commissioner issued his first Revenue Ruling, there have been two dramatic changes in the financing of health care delivery. First, hospital costs have risen to astronomical proportions, placing private hospitals in precarious financial straits. Second, the development of both private and public health insurance (Medicare and Medicaid) has largely displaced self-paying patients and private philanthropy as the principal source of hospital revenue. The institution of these public assistance programs since the publication of the first Revenue Ruling has resulted in the admission and treatment by private hospitals of large numbers of insured persons of whom a substantial percentage, in the absence of such governmental reimbursement, would be unable to pay hospitalization costs. Thus, a private hospital which meets the criteria of the current Revenue Ruling and admits any patient with some form of health insurance, is accepting many of those persons who would have required free or below-cost care in 1956. As a result, the free care for indigents required by the prior Revenue Ruling is of lesser significance for the health care of the poor today than it was in 1956.

Finally, the indigent care requirement of the prior Revenue Ruling, which petitioners seek to have restored to universal application, proved to be administratively unworkable in practice. The standard of that Ruling for ascertaining a hospital's ability to provide health care to the poor—"to the extent of its

financial ability"—is virtually impossible to apply fairly. Even if a hospital has surplus funds available, its "financial ability" to furnish free services cannot be measured meaningfully against its need for new technological equipment or training programs. Under the financial ability test of the old Ruling, the Internal Revenue Service presumably would have to determine how much a hospital should spend for free care and how much for other crticial needs, a task for which it is singularly ill-equipped. However, the standards implicit in the current Revenue Ruling are less likely to involve the Treasury in formulating guidelines with respect to details of hospital administration.

III

The court of appeals correctly held that Rev. Rul. 69-545 was not subject to the notice and hearing requirements of the Administrative Procedure Act because it came within the Section 553(b)(3)(A) exception for "interpretative rule[s]." As that court observed, it is well settled that agency rulings that do not bind the affected parties or the courts are interpretative within the meaning of Section 553(b)(3)(A). Unlike the cases relied upon by petitioners, which involve substantive agency orders with binding legal effect, the published Revenue Ruling at issue here is only an interpretation by the Treasury of the statutory term "charitable." Such a ruling is informational in character and represents an announcement of position in much the same way as a speech by a Treasury official or an argument presented to a court.

ARGUMENT

I. THE FEDERAL COURTS MAY NOT REVIEW THE CORRECTNESS OF REVENUE RULINGS MADE BY THE DEPARTMENT OF THE TREASURY IN EQUITY SUITS BROUGHT BY PERSONS WHOSE OWN TAX LIABILITIES ARE NOT AT ISSUE

A. Congress Has Vested The Administration Of The Revenue Laws Exclusively In The Department Of The Treasury

1. *Introduction*

The jurisdictional question in No. 74-1124, presented by the petition of the Secretary of the Treasury, is of paramount importance to the orderly administration of the revenue laws. In holding that a federal court, at the behest of persons whose own tax liabilities are not at issue, can review the correctness of a Revenue Ruling issued by the Treasury and enjoin its implementation if it concludes that the Ruling is erroneous, the court of appeals has arrogated to the Judicial Branch the function of administering the tax laws which Congress has vested exclusively in the Executive Branch in the Department of the Treasury.

While Congress has prescribed various procedures for judicial review by taxpayers of Treasury determinations of their tax liability,[5] no taxes of any

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[5] Congress has established a statutory scheme which generally provides taxpayers with two methods of obtaining judicial review of tax disputes with the Treasury. First, with respect to income, estate, and gift taxes, a taxpayer may obtain review of a notice of deficiency without having to pay the disputed amount by filing a timely petition in the Tax

organization or person are directly at issue in this case. To the contrary, petitioners seek to compel revision of the current criteria of the Department of the Treasury under which private hospitals are accorded tax-exempt status. In so doing, petitioners hope, through the mechanism of this suit, to change what they perceive as the present hospital policies governing the extent to which private hospitals furnish medical care for the indigent. Petitioners thus seek to use the Internal Revenue laws to effect a broad transformation in the social structure.

As we shall demonstrate, the courts have no jurisdiction to entertain such a suit. Indeed, the broad nature of petitioners' requested relief—compelling the Treasury to revoke an outstanding Revenue Ruling, to issue another ruling in its stead, and to revoke the tax-exempt status of all hospitals whose activities do not conform to petitioners' interpretation of the term "charitable" in Section 501(c)(3) of the Internal Revenue Code of 1954—requires the judiciary to play an unprecedented role in the administration of the revenue laws, which is generally reserved by statutory provisions to the Executive Branch under congressional supervision. As this Court has had occasion during the last decade to

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Court. Sections 6212 and 6213 of the Code. Alternatively, a taxpayer may pay the disputed amount of any type of tax, file a claim for refund, and obtain judicial review of the Commissioner's denial of the claim (or his failure to act on the claim within six months) by a suit for refund in a district court or in the Court of Claims. Sections 6532 and 7422 of the Code; 28 U.S.C. 1346 and 1491.

observe in the context of two refund suits (*United States* v. *Correll*, 389 U.S. 299, 306-307; *Bingler* v. *Johnson*, 394 U.S. 741, 750-751), but in terms equally applicable to petitioners' claim for judicial revision of the Commissioner's ruling—

> [W]e do not sit as a committee of revision to perfect the administration of the tax laws. Congress has delegated to the Commissioner, not to the courts, the task of prescribing "all needful rules and regulations for the enforcement" of the Internal Revenue Code. 26 U.S.C. § 7805(a). In this area of limitless factual variations, "it is the province of Congress and the Commissioner, not the courts, to make the appropriate adjustments." *Commissioner* v. *Stidger*, 386 U.S. 287, 296.

2. The role of the rulings program in tax administration

Petitioners' attempt to compel the revocation of a published Revenue Ruling, if successful, would seriously impair the effectiveness of the Treasury's entire rulings program. Each year, in response to formally submitted requests, the Internal Revenue Service issues approximately 40,000 advance letter rulings setting forth its opinion concerning the federal tax consequences of specific proposed transactions. In most circumstances, the issuance of a ruling gives the affected taxpayers sufficient indication of the tax effects of a transaction so that they can consummate it.

Many of these letter rulings, as contemplated by Section 508(a) of the Internal Revenue Code of 1954,

are issued to organizations desiring recognition of their tax-exempt status under Section 501(c)(3) of the Code, as "organized and operated exclusively for religious, charitable * * * or educational purposes." In those instances, the Commissioner has stated that generally contributions to such organizations will be considered deductible under Section 170(a) of the Code, as long as the ruling is outstanding, even if it is subsequently revoked retroactively. Rev. Proc. 72-39, 1972-2 Cum. Bull. 828.

Of the thousands of letter rulings it issues each year, the Internal Revenue Service selects and edits several hundred for publication in its Bulletin in more abstract and anonymous form as Revenue Rulings. The aim of this publication program is to inform subordinate revenue officials, taxpayers and their representatives of the established policies of the Internal Revenue Service.[6] Thus, the published rulings program, which is designed to instruct the public with respect to the application of the technical provisions of the Internal Revenue Code, contributes in large measure to uniformity of interpretation of the tax law and thereby enhances public compliance with the revenue statutes. Moreover, by establishing a reliable mechanism of advance information, the Revenue Rulings program promotes the stability of our self-reporting tax system by reducing contro-

[6] This is the stated purpose of the Revenue Rulings system. See Rev. Rul. 2, 1953-1 Cum. Bull. 484; Rev. Rul. 212, 1953-2 Cum. Bull. 449.

versies and litigation.[7] In this respect, the Internal Revenue Service is unique. No other agency of the federal government maintains such an ambitious and wide-ranging program of making known its current interpretive opinions respecting the statute it is charged to administer.

Although the present Revenue Rulings and letter rulings programs are the product of an administrative reorganization in 1953,[8] the issuance of in-

[7] The Commissioner has the power to revoke a Revenue Ruling or a letter ruling retroactively if it is contrary to law. See Section 7805(b) of the Code; *Automobile Club of Michigan* v. *Commissioner*, 353 U.S. 180; *Dixon* v. *United States*, 381 U.S. 68, 71; Introduction, 1969-2 Cum. Bull. xxii. However, in order to encourage reliance upon published Revenue Rulings, it is the announced policy of the Internal Revenue Service ordinarily to make revocation of such Rulings prospective only. Rev. Proc. 72-1, 1972-1 Cum. Bull. 693, 694. In the case of a letter ruling, the policy of the Service is that it will generally revoke or modify it retroactively only if there has been a misrepresentation or an omission of a material fact in the application for the ruling. See Section 13, Rev. Proc. 72-3, 1972-1 Cum. Bull. 698, 705-706. Moreover, if the Internal Revenue Service intends to revoke or modify its recognition of an organization's tax-exempt status, there is a prescribed procedure of formal notice and hearings. See Rev. Proc. 72-4, 1972-1 Cum. Bull. 706; *Bob Jones University* v. *Simon*, 416 U.S. 725, 730. For a general description of the entire rulings program, see Rogovin, *The Four R's: Regulations, Rulings, Reliance and Retroactivity*, 43 Taxes 756 (1965); and Caplin, *Taxpayer Rulings Policy of the Internal Revenue Service*, 20 N.Y.U. Fed. Tax Inst. 1 (1962).

[8] In 1953, the various types of opinions, such as General Counsel's Memoranda (G.C.M.'s) and Solicitor's Opinions (Sol. Op.'s), were consolidated into a single category known as Revenue Rulings. Revenue Procedures (Rev. Proc.'s) con-

terpretive rulings by the Treasury has been an essential part of its administration of the revenue laws from the earliest days of the Republic. When the Department of the Treasury was established and the office of Secretary of the Treasury was created by the Act of September 2, 1789, 1 Stat. 65, Section 2 of that Act provided that it was "the duty of the Secretary of the Treasury * * * to superintend the collection of the revenue." See currently Revised Statutes, Section 248, 31 U.S.C. 1002. By 1792, Secretary Hamilton had already addressed "Circulars" to collectors instructing them in the "true construction" of the revenue acts.[9] These directives by the first Secretary of the Treasury primarily served as internal instructions to his subordinates.

Subsequently, synopses of such administrative opinions were published (see, *i.e.*, Treasury Department, Synopsis of Decisions (1868)) and gradually the number and types of opinions increased.[10] The available

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tinue to be issued by the Service but they deal with matters of internal procedures rather than substantive tax law. See Rev. Proc. 55-1, 1955-2 Cum. Bull. 897.

[9] One such "Circular" dealt with the proper leakage allowance for purposes of the taxes on distilled spirits and molasses. See Circular of August 27, 1792, reproduced in *The Work and Jurisdiction of the Bureau of Internal Revenue*, p. 9 (Government Printing Office, 1948).

[10] See, for example, the various types of published Rulings listed in 1952-1 Cum. Bull. v-vi. In addition, opinions of the Attorney General sometimes served the same purposes as published Revenue Rulings. See *e.g.*, 39 Ops. A.G. 261-266 (March 18, 1939); 25 Ops. A.G. 605-607 (May 7, 1906); 24 Ops. A.G. 1-8 (March 12 and 19, 1902); 1 Ops. A.G. 345-346

records show that at least as early as 1913, the Internal Revenue Service (then the Bureau of Internal Revenue) maintained a policy of answering taxpayers' questions concerning interpretations of tax statutes. By 1938, there was considerable public sentiment to make such responses binding upon the Service.

As a result, Congress authorized the Service to enter into closing agreements with respect to prospective transactions which would fix their tax consequences for the pertinent years. See Section 801, Revenue Act of 1938, 52 Stat. 573. Because this procedure proved cumbersome, the Internal Revenue Service established the present letter rulings program in 1953, which in practical terms accomplished much the same result without the necessity for formal closing agreements.[11] See Rev. Rul. 10, 1953-1 Cum. Bull. 488.

As the foregoing history indicates, the effectiveness of the rulings program is in large measure attributable to the high degree of reliance the public has placed upon letter rulings and Revenue Rulings reflecting the position of the Treasury with respect to

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(March 31, 1820); 1 Ops. A.G. 269-270 (April 15, 1819). On occasion, such opinions were included in Internal Revenue compilations. See, *e.g.*, T.D. 3570, III-1 Cum. Bull. 85 (1924), considered in *Squire* v. *Capoeman*, 351 U.S. 1, 8-9, n. 14.

[11] Although the Commissioner has the power to revoke a Revenue Ruling or a letter ruling retroactively, it is the announced policy of the Internal Revenue Service ordinarily to make such revocations prospective only in order to encourage taxpayer reliance. See n. 7, *supra*.

questions arising under the Internal Revenue Code. While the rulings program is primarily designed to provide information to the public, as a practical matter it represents the announced word of the government that it will generally adhere to a particular statutory interpretation or tax policy until further notice. In holding that a revenue ruling should be revoked retroactively simply on the basis of another view of the law, the decision of the district court has impaired the element of reliance inherent in the rulings system and has thereby greatly reduced the effectiveness of this program of tax administration. If the federal courts could generally order the retroactive revocation of a Revenue Ruling at the behest of persons whose own tax liabilities were not at issue, the consequences would be three-fold. First, the elimination of predictability of result would unquestionably increase the number of controversies and litigated cases, thereby multiplying the burdens upon the courts. Second, it would impose uncertainty upon a large number of financial transactions in which the tax consequences were at all unclear, thereby impairing the incidence of normal commercial transactions. Third, as this case demonstrates, it would to some extent reduce the ability of organizations to represent with certainty their tax-exempt status to prospective donors.

By concluding that the courts are empowered to exercise general reviewing authority over published Revenue Rulings, the jurisdictional holding of the court of appeals discourages the Internal Revenue

Service from making public its views on questions arising under the tax statutes. It invites anyone who disagrees with a letter ruling or a published Revenue Ruling to sue the responsible Treasury officials to enjoin them from taking any action consistent with the Ruling. One would suppose that such a radical departure from accepted norms would not have been made without specific congressional authorization for such judicial review of the actions of the properly constituted federal tax officials.

There is, however, no such statutory authorization. To the contrary, an examination of the pertinent provisions of the present Internal Revenue Code and its predecessor Revenue Acts, to which we now turn, reveals a consistent congressional intent to vest the administration of the tax laws exclusively in the Department of the Treasury.

3. *The statutory provisions governing tax administration vest broad discretion in the Secretary of the Treasury*

The administration of the revenue laws in general, and the implementation of the Revenue Rulings and letter rulings programs in particular, necessarily require the exercise of a wide latitude of judgment by the responsible officials of the Department of the Treasury.[12]

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[12] For example, in Rev. Proc. 72-9, 1972-1 Cum. Bull. 719, the Internal Revenue Service has announced a list of those areas in which it will not issue advance rulings or determination letters.

It is therefore hardly surprising that from the very inception of the Treasury as the tax-collecting arm of the federal government, Congress has vested in its officials broad discretion in the enforcement of the revenue laws. Pursuant to its authority under the Constitution to "lay and collect Taxes, Duties, Imposts and Excises" (Article I, Section 8), Congress provided in 1792 that "the Secretary of the Treasury shall direct the superintendence of the collection of the duties on impost and tonnage *as he shall judge best.*" Act of May 8, 1792, 1 Stat. 280, Section 6 (emphasis supplied). The congressional debates surrounding the creation of the office of the Secretary of the Treasury indicate that some members of Congress were fearful of giving such broad powers to a single individual, especially when the Constitution mentioned no such office. See 1 Annals of Congress, pp. 384-389 (1834).

However, the grant of such broad authority proved successful. Thus, in 1862, when Congress reimposed internal taxes, it created a second office of Commissioner of Internal Revenue, who was "charged, under the direction of the Secretary of the Treasury, with preparing all the instructions, regulations, directions * * *, and all other matters pertaining to the assessment and collection of the duties, stamp duties, and taxes, which may be necessary to carry this act into effect * * *." See Act of July 1, 1862, 12 Stat. 432-433.[13]

[13] Originally, the Act of May 8, 1792, 1 Stat. 280, Section 6, established the office of Commissioner of the Revenue. However, that office was abolished by Section 2 of the Act of April 6, 1802, 2 Stat. 148, upon its repeal of the internal taxes. The office was again created by the Act of July 24, 1813, 3 Stat. 39, Section 1, coincident with the reimposition of internal taxes, and again abolished upon their repeal by the Act of December 23, 1817, 3 Stat. 401.

Similarly, the current statutory provisions cast the authority of the Secretary of the Treasury and the Commissioner of Internal Revenue in the broadest possible terms. Thus, for example, Section 7801 of the Internal Revenue Code of 1954 provides that "Except as otherwise expressly provided by law, the administration and enforcement of [the revenue laws] shall be performed by or under the supervision of the Secretary of the Treasury." Section 7802 is the present statutory basis for the Commissioner of Internal Revenue, who "shall have such duties and powers as may be prescribed by the Secretary."[14]

[14] Section 3901(a) of the 1939 Code had provided generally that "The Commissioner, under the direction of the Secretary * * * (1) [s]hall have general superintendence of the assessment and collection of all taxes imposed by any law providing internal revenue." This derived from Revised Statutes, Section 321, 31[illegible] U.S.C. 1002, and, ultimately, from the Act of June 30, 1862, 13 Stat. 223. Other more specific grants of authority in the 1939 Code, as in earlier Revenue Acts, were principally either to the Commissioner (*e.g.*, Sections 3614, 3640), or to the Commissioner with the approval of the Secretary (*e.g.*, Sections 3743, 3760, 3761).

Reorganization Plan No. 26 of 1950, 64 Stat. 1280, Section 1, transferred "to the Secretary of the Treasury all functions of all other officers of the Department of the Treasury and all functions of all agencies and employees of such Department," and authorized the Secretary to make such provisions as he should deem appropriate authorizing the performance of

Complementing the authority vested in the Secretary of the Treasury and the Commissioner of Internal Revenue to administer and enforce the tax laws is their authority to make rules and regulations granted by Section 7805(a) of the Code. That provision, which dates at least as early as 1862 when the current office of Commissioner was established, states that "Except where such authority is expressly given by this title to any person other than an officer or employee of the Treasury Department, the Secretary or his delegate [the Commissioner] shall prescribe all needful rules and regulations for the enforcement of this title * * *."[15] This discretionary rule-making responsibility requires a high degree of technical competence and understanding of the complex interrelationships of the taxing provisions of the Code, coupled with the wisdom that only the long

functions by any other officer, agency, or employee of the Department. See also Reorganization Plan No. 1 of 1952, 66 Stat. 823. The Secretary in turn delegated to the Commissioner the direct responsibility for the operations of the Bureau of Internal Revenue, now the Internal Revenue Service. Treasury Dept. Order No. 150-2, May 15, 1952 (Annual Report of the Secretary of the Treasury 1951-1952, p. 485). Section 7804 of the Internal Revenue Code of 1954 makes the provisions of these Reorganization Plans applicable to all functions vested by the Code. See generally H.R. Rep. No. 1337, 83d Cong., 2d Sess. A438-A439 (1954); S. Rep. No. 1622, 83d Cong., 2d Sess. 620-621 (1954).

[15] In addition, the Code contains a number of specific grants of authority to the Secretary to make what are often designated as "legislative" Regulations. *Ilfeld Co.* v. *Hernandez*, 292 U.S. 62, 65. See, *e.g.*, Sections 167(b), 1502.

institutional experience of the Internal Revenue Service can give. Thus, the Code properly centralizes the rule-making function in the Commissioner of Internal Revenue. See Paul, *Taxation in the United States*, pp. 665-666 (1954); Eisenstein, *Some Iconoclastic Reflections on Tax Administration*, 58 Harv. L. Rev. 477, 526-527 (1945).

Other statutory grants of authority to the Treasury are equally as broad and have their roots in provisions long antedating the modern income tax. Section 6201(a) gives to the Secretary or his delegate the vital and sweeping authority "to make the inquiries, determinations, and assessments of all taxes * * * imposed by this title." This provision was intended to vest exclusively in the office of the Commissioner the responsibility and authority for enforcement in its three separate aspects: inquiries, determinations and assessments. It was a conscious choice on the part of the Congress to concentrate such responsibility and authority in a single official.[16] Furthermore, to make it clear that this responsibility is not to be shared, Section 7401 of the Code provides that "No civil action for the collection or recovery of taxes * * * shall be commenced unless the Secretary or his delegate authorizes or sanctions

[16] Section 6201 originated in the Act of December 24, 1872, 17 Stat. 402, Section 2, and abolished the offices of assessor and assistant assessor. The predecessor of Section 6201 was recommended by Commissioner Douglass in his *Report of the Commissioner of Internal Revenue for the Fiscal Year ended June 30, 1872*, p. xix.

the proceedings and the Attorney General or his delegate directs that the action be commenced".[17]

Finally, the Code also gives the Commissioner of Internal Revenue comprehensive responsibility and authority to refund or credit taxes erroneously or illegally collected (Section 6402),[18] to compromise civil or criminal cases arising under the internal revenue laws (Section 7122),[19] to enter into final and conclusive (absent fraud, malfeasance or misrepresentation) closing agreements with respect to tax liability for past or prospective transactions (Section 7121),[20] and to abate excessive, erroneous

[17] Section 7401 of the 1954 Code originated in Section 9 of the Act of July 13, 1866, 14 Stat. 101, 111. Previously, the Collectors had been authorized to initiate suits for the recovery of taxes. Act of July 1, 1862, 12 Stat. 44, Section 31. The reference to the Attorney General originated in Section 3740 of the 1939 Code and reflected Section 5 of Executive Order No. 6166 of June 10, 1933, which vested in the Attorney General and the Department of Justice the authority to conduct the government's tax litigation other than before the Board of Tax Appeals.

[18] This provision, carried forward from Sections 322(a), 1027(a), and 3770(a) of the 1939 Code, originated in Section 44 of the Act of June 30, 1864, 13 Stat. 239.

[19] This provision, carried forward from Section 3761 of the 1939 Code, also originated in Section 44 of the Act of June 30, 1864, *supra*.

[20] This provision, carried forward from Section 3760 of the 1939 Code, originated in Section 606 of the Revenue Act of 1928, 45 Stat. 874, where it related only to taxable periods ending prior to the date of the agreement. Section 801 of the Revenue Act of 1938, 52 Stat. 573, eliminated the restriction to prior periods.

or illegal assessments (Section 6404).[21] Absent fraud or mistake in mathematical calculation, Section 6406 provides that the findings of fact and decision on the merits of the Secretary or his delegate in allowing claims for refund shall not be subject to review by any other administrative or accounting officer of the United States.[22]

Pursuant to the predecessors of this latter statutory directive, this Court has long ago held that absent fraud or mistake appearing on the record, no other officer of the federal government may seek to recover a refund allowed a taxpayer by the Commissioner of Internal Revenue within the exercise of his exclusive statutory discretion over the administration of the tax laws. *United States* v. *Kaufman*, 96 U.S. 567; *United States* v. *Savings Bank*, 104 U.S. 728; *United States* v. *Louisville*, 169 U.S. 249. Accord: *Woolner* v. *United States*, 13 Ct. Cl. 355; *United States* v. *Detroit Steel Products Co.*, 20 F.2d 675 (E.D. Mich.); *Sybrandt* v. *United States*, 19 Ct. Cl. 461. The proposition that private parties, such as

[21] This provision, carried forward from Section 3770(a)(5) of the 1939 Code, originated in Section 44 of the Act of June 30, 1864, *supra*.

[22] This provision, carried forward from Section 3790 of the 1939 Code, originated in Section 1007 of the Revenue Act of 1924, 43 Stat. 340. It had been recommended by a representative of the Treasury Department in 1921 (Statement by Dr. T. S. Adams, Senate Hearing on Internal Revenue, September 15, 1921). It was enacted in 1924 specifically to make it clear that the allowance of tax refunds was not subject to review by the Comptroller General. H.R. Conf. Rep. No. 844, 68th Cong., 1st Sess. 31 (1924); 65 Cong. Rec. 7141 (1924).

petitioners, should not be able to set aside the action of the Commissioner with respect to a particular taxpayer or group of taxpayers follows *a fortiori* from these decisions.

4. *This suit is not appropriate for judicial resolution*

a. The broad authority that Congress has given the Secretary of the Treasury and the Commissioner of Internal Revenue over the administration of the tax laws shows that it did not intend the courts to entertain suits of this kind. Nothing in the Internal Revenue Code or any other act of Congress suggests that Congress ever intended the courts to have general review authority over the administration of the revenue laws other than their jurisdiction to hear deficiency or refund suits brought by taxpayers contesting their liability. The statutory system implements James Madison's concept that the role of the Judicial Branch in the tax area is to consider "the claims and accounts subsisting between the United States and particular citizens" (1 Annals of Congress, *supra*, at 612).[23] See also *id.* at 386-389, 592-602, 612-614.

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[23] Indeed, even within the context of a refund suit, the Court has indicated that review of the Commissioner's discretion is necessarily limited. In *Williamsport Co.* v. *United States*, 277 U.S. 551, the taxpayer argued that the Commissioner should have made a special assessment based upon the average tax of representative corporations. The Court refused to review the Commissioner's decision not to make such a special assessment, stating (pp. 560-561):

> It is true that where the Commissioner's action is reviewable judicially, his findings of fact in making an assessment, as distinguished from his determinations involving administrative discretion * * * are commonly reviewable by courts in appropriate proceedings * * *. But such problems involve primarily the situation of a single taxpayer, and the controlling data can easily be made available to the court. Here, the considerations * * * are facts * * * which can only be known to an official or a body having wide experience in such matters and ready access to the means of information.

If there is any limitation on the authority of the Executive Branch over tax administration, it is the oversight exercised by Congress through the Joint Committee on Internal Revenue Taxation (see Sections 8001, 8002, 8021 and 8022 of the Code) [24] and through the various committees responsible for the enactment of the tax legislation and government operations.[25] Thus, pursuant to its constitutional power

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[24] See also Section 6405(a) of the Code, which provides that the Commissioner shall make no refund or credit of tax in excess of $100,000, until the expiration of 30 days from the submission of an explanatory report to the Joint Committee on Internal Revenue Taxation.

[25] The administration of the tax law has been the subject of a number of legislative hearings and reports. See, *e.g.*, Prevention of Tax Avoidance, Preliminary Report of a Subcommittee of the Committee on Ways and Means, 73d Cong., 2d Sess. (1933); Proposals for Strengthening Tax Administration, Hearings before a Subcommittee of the Committee on Ways and Means, 82d Cong., 2d Sess. (1952). Indeed, the very substantive issue in this case—the tax-exempt status of hospitals—was the subject of a Staff Report to the Senate Committee on Finance on Medicare and Medicaid, 91st Cong., 1st Sess. (1970) (A. 38-46). Finally, we are advised by the Internal Revenue Service that during the period January 1974, through June 1975, the Commissioner of Internal Revenue made 29 appearances before congressional committees in connection with legislative inquiries into Internal Revenue Service policies.

to "lay and collect Taxes," Congress has subjected the Department of the Treasury to the supervision inherent in the political process.

Given the constitutional and statutory commitment to vest the administration of the revenue laws exclusively in the Executive Branch, this suit to compel the Treasury to change its policy regarding the tax-exempt status of hospitals is not appropriate for judicial resolution. If one person could bring an action against the Treasury objecting to the tax treatment accorded another person, the courts would quickly be drawn into performing the tax administration function reserved to the Executive Branch. Indeed, if petitioners can maintain this action, there are many others who could utilize litigation with the Internal Revenue Service as a sword to be wielded against adversaries.

Such litigation could be brought to compel the Internal Revenue Service to audit a particular taxpayer according to standards that the plaintiff insisted were required by the statute rather than those employed by the Service. One business could sue to compel the imposition of a heavier tax burden on a competitor. The institution of such suits would require the Treasury to channel its energies in the pursuit of questions deemed important not by it but by a host of private plaintiffs who claim to assert the public interest but who have no ultimate responsibility for tax administration. This would deprive the Treasury of the discretion and flexibility necessary to collect the taxes which this Court has characterized as "the life-blood of government". *Bull* v. *United States*, 295 U.S. 247, 259. Moreover, such suits would "create the potential for abuse of the judicial process, distort the role of the Judiciary in its relationship to the Executive and the Legislature and open the Judiciary to an arguable charge of providing 'government by injunction'." *Schlesinger* v. *Reservists to Stop the War*, 418 U.S. 208, 222.

Of course, we do not suggest that policies of the Internal Revenue Service should be immune from public inquiry and examination. The broad tax policy questions raised by petitioners' suit are properly a matter for public debate. However, the appropriate forum for such a debate concerning the correctness of Treasury policy is in the Congress pursuant to the exercise of its oversight of the Department of the Treasury and not in the courts. "Any other conclusion would mean that the Founding Fathers intended to set up something in the nature of an Athenian democracy or a New England town meeting to oversee the conduct of the National Government by means of lawsuits in federal courts." *United States* v. *Richardson*, 418 U.S. 166, 179.

b. This is not the first instance in which this Court has been asked to require the Treasury to increase the tax burden of others who were not even parties to the litigation. In *Louisiana* v. *McAdoo*, 234 U.S. 627, the State of Louisiana; itself a producer of sugar, sought an order requiring the Secretary of the Treasury to collect higher duties on im-

ported sugar.[26] As in the instant case, the Secretary's construction (T.D. 34241, 26 Treas. Dec. (Customs) 332) of the relevant statutes was analogous to a Revenue Ruling, and as was often the case, was in accordance with an Opinion of the Attorney General (30 Ops. A.G. 259 (1914)) (see n. 10, *supra*).

In dismissing the suit, the Court refused to consider the merits of Louisiana's claim challenging the statutory discretion of the Secretary. It observed that the maintenance of such actions "would operate to disturb the whole revenue system of the Government" (234 U.S. at 632) and that "[i]nterference [by the

[26] In *Louisiana* v. *McAdoo, supra*, the Court was well aware of the unprecedented nature of the suit. As Solicitor General Davis stated in the government's brief in that case (October Term, 1913, Orig., p. 10), "From 1789 to 1890 there is no record of any attempt to review the decision of a collector or of the Secretary where the rate of duty imposed was alleged to be too low, and no such right exists at this time."

In 1922, Congress enacted a limited statutory exception to the general rule established in *Louisiana* v. *McAdoo, supra*. It allowed domestic manufacturers to intervene in proceedings to establish the value and tax classification of imported goods. Act of September 21, 1922, 42 Stat. 970, Section 516. However, the courts have uniformly held that, apart from cases arising under the Section 516 manufacturers' protest statute, they have no jurisdiction to entertain third-party suits challenging an allegedly too favorable tax treatment of another. *Feltex Corp.* v. *Dutchess Hat Works*, 71 F.2d 322, 328 (Cust. & Pat. App.); *Fletcher* v. *United States*, 92 F.2d 713, 717 (Cust. & Pat App.); *Calf Leather Tanners' Ass'n* v. *Morgenthau*, 80 F.2d 536 (C.A. D.C.); *Morgantown Glassware Guild* v. *Humphrey*, 236 F.2d 670 (C.A. D.C.); see also *J. C. Penney Co.* v. *United States Treasury Dept.*, 439 F.2d 63 (C.A. 2), certiorari denied, 404 U.S. 869.

courts] in such a case would be to interfere with the ordinary functions of government" (*id.* at 633).[27]

Earlier, in *Dorsheimer* v. *United States*, 7 Wall. 166, the Court dismissed a suit brought by a collector of internal revenue and two informers for their then-existing statutory right to one-half of an amount received by the government as a penalty or forfeiture in the compromise of a liquor tax violation. The compromise approved by the Secretary of the Treasury had waived the fraud penalty and thereby eliminated the plaintiffs' reward. In holding that the Secretary's remission of the penalty was not reviewable, the Court stated that "[i]t was the exercise of his discretion in a matter intrusted to him alone, and from which there could be no appeal" (*id.* at 175).

Thus, even though the plaintiffs suffered a direct financial detriment as a result of the Secretary's action, his discretion to lessen the tax burden of a particular taxpayer could not be challenged in the courts. Similarly, the Executive's policy concerning the cri-

[27] Petitioners make little effort to distinguish the force of *Louisiana* v. *McAdoo*, stating (Br. 59) that it rests "on an outdated notion of standing" and that "it has long been overruled." But the Court has cited *Louisiana* v. *McAdoo* without question or disapproval in *Dalehite* v. *United States*, 346 U.S. 15, 34, n. 30; *Aircraft & Diesel Corp.* v. *Hirsch*, 331 U.S. 752, 763, n. 18; *Switchmen's Union* v. *Board*, 320 U.S. 297, 303; *Arizona* v. *California*, 298 U.S. 558, 572; *Oregon Basin Oil & Gas Co.* v. *Work*, 273 U.S. 660, 661; and *Johnson* v. *McAdoo*, 244 U.S. 643. It was also cited in dissenting opinions in *Larson* v. *Domestic & Foreign Corp.*, 337 U.S. 682, 710, n. 2, 716, 729, and in *Anti-Fascist Committee* v. *McGrath*, 341 U.S. 123, 204-205.

teria for the tax-exempt status of hospitals—a policy that lessens the taxes of a particular class—is not an appropriate subject for review by the Judicial Branch.[28]

c. Finally, there is another aspect of this case that demonstrates that it is not appropriate for judicial resolution. Petitioners seek a judgment that will revoke Rev. Rul. 69-545 and determine that an unidentified hospital, Hospital *A*, and other hospitals that may to some undefined extent be similarly situated, are not exempt from federal income tax under Section 501(c)(3) of the Code. While the facts set forth in that Ruling are somewhat sparse, they do indicate that Hospital *A* was engaged in educational and research activities that might become highly relevant in establishing its exempt status, even if it did not make its facilities generally available to the indigent. Suppose, for example, a hospital were organized for the treatment and research of a particular rare disease. If it restricted admissions to those persons so affected, the fact that it did not admit any indigent persons would not appear to jeopardize its exempt status as an educational or scientific organization. The district court's revocation of Rev. Rul.

[28] See also *Wolkstein* v. *Port of New York Authority*, 178 F. Supp. 209 (D. N.J.), holding that a suit to enjoin the Commissioner's recognition of the tax-exempt status of the Port of New York Authority was barred by Section 7401 of the Code, which vests in the Attorney General the sole authority to bring suits at the request of the Commissioner for the collection of taxes. Accord: *United States ex rel. Roberts* v. *Western Pac. R. Co*, 190 F.2d 243, 248 (C.A. 9).

69-545 and the contrary disposition by the court of appeals, which focus upon only the single factor of treatment of the indigent, will therefore not necessarily control the status of a single identifiable hospital. Even if the court of appeals had affirmed the district court in all respects, each hospital would have remained free to litigate its own right to exemption on its own particular facts. Under these circumstances, the judgments of the courts below with respect to the hypothetical facts of the two Revenue Rulings amount to little more than advisory opinions which no federal court is constitutionally authorized to render.

B. Petitioners Have No Standing To Challenge The Treasury's Revenue Ruling

1. The impropriety of the court's entertainment of petitioners' challenge to the Commissioner's Revenue Ruling is also shown by their lack of standing to maintain such an action. This Court has consistently held that the Article III limitation to "cases" and "controversies" requires a party seeking judicial relief to possess a specific interest in the outcome of the controversy. This requirement is designed to insure that the issues will be presented "in an adversary context and in a form historically viewed as capable of judicial resolution," *Sierra Club* v. *Morton*, 405 U.S. 727, 732, and will involve something more than "generalized grievances about the conduct of government or the allocation of power in the Federal System," *Flast* v. *Cohen*, 392 U.S. 83, 106. See also

United States v. *Richardson*, 418 U.S. 166; *Schlesinger* v. *Reservists to Stop the War*, 418 U.S. 208.

While recent decisions of this Court have somewhat broadened the categories of injury that may be alleged in support of standing, the Court also has recently observed that it has "steadfastly adhered to the requirement that, at least in the absence of a statute expressly conferring standing, federal plaintiffs must allege some threatened or actual injury resulting from the putatively illegal action before a federal court may assume jurisdiction" (footnote and citations omitted). *Linda R.S.* v. *Richard D.*, 410 U.S. 614, 617. There, the plaintiff, the mother of an illegitimate child, brought an action to enjoin the "discriminatory application" of a state statute which provided a criminal penalty for the failure of a father to support his children. Although the plaintiff asserted that she had made application to the local district attorney for enforcement of the statute against the father of her illegitimate child, the district attorney refused to take action because, in his view, the fathers of illegitimate children were not within the scope of the statute. Despite the plaintiff's interest in her child's support, the Court dismissed her suit for lack of standing because, *inter alia*, "a private citizen lacks a judicially cognizable interest in the prosecution or nonprosecution of another" (410 U.S. at 619).

The principle of *Linda R.S.* is fully applicable here and requires dismissal of this suit. The Court there noted (410 U.S. at 619) that its prior de-

cisions "consistently hold that a citizen lacks standing to contest the policies of the prosecuting authorities when he himself is neither prosecuted or threatened with prosecution." See *Younger* v. *Harris*, 401 U.S. 37, 42; *Bailey* v. *Patterson*, 369 U.S. 31, 33; *Poe* v. *Ullman*, 367 U.S. 497, 501. Just as the plaintiff in *Linda R.S.* had no standing to contest the nonprosecution of the father of her child, petitioners here have no standing to challenge the Treasury's decision not to tax certain hospitals described in Rev. Rul. 69-545. As this Court has often held, one charged with the task of prosecuting violations of a statute must possess the discretion both to prosecute and to refrain from doing so. See, *e.g.*, *Confiscation Cases*, 7 Wall. 454; *Federal Trade Commission* v. *Klesner*, 280 U.S. 19, 25; *Vaca* v. *Sipes*, 386 U.S. 171, 182. Accord: *Georgia* v. *Mitchell*, 450 F.2d 1317 (C.A. D.C.); *Powell* v. *Katzenbach*, 359 F.2d 234 (C.A. D.C.), certiorari denied, 384 U.S. 906; *Peek* v. *Mitchell*, 419 F.2d 575 (C.A. 6). But compare *Bachowski* v. *Brennan*, 502 F.2d 79, 86-88 (C.A. 3), reversed and remanded on other grounds *sub nom. Dunlop* v. *Bachowski*, No. 74-466, decided June 2, 1975 (slip op. 5-7).[29]

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[29] In *Bachowski* v. *Brennan*, 502 F.2d 79 (C.A. 3), reversed and remanded on other grounds *sub nom. Dunlop* v. *Bachowski*, No. 74-466, decided June 2, 1975, the court held that a disappointed union office seeker could invoke the judicial process to compel the Secretary of Labor to bring an action under Title IV of the Labor Management Reporting and Disclosure Act to set aside a union election. The court of appeals (502 F.2d at 86-88) rejected the Secretary's contention that

There is no meaningful difference between the Secretary of the Treasury's role in enforcing the Internal Revenue Code and the role of other prosecutors whose judgment has remained free from judicial control. Here, petitioners not only seek revocation of a published Revenue Ruling but also an injunction requiring the Commissioner to revoke his recognition of the tax-exempt status of hospitals that did not admit indigents and to collect the taxes from such hospitals (A. 27-28). But the Commissioner's legal conclusion as to what taxpayers to subject to audit and assessment of additional taxes surely rests within his discretion, and his decisions in this regard cannot be the subject of judicial review. Just as this Court in *Linda R.S.* was unwilling to review the decision of a local prosecutor that a certain class of individuals were not subject to prose-

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his decision was an unreviewable exercise of prosecutorial discretion, and this Court (slip op. at 6, n. 7) agreed with that disposition.

However, the court of appeals expressed the view that the doctrine of prosecutorial discretion should be limited to those civil cases which, like the criminal prosecutions, involve the vindication of a societal or governmental interest, rather than the protection of individual rights such as those of union members preserved by the Labor Management Reporting and Disclosure Act. Unlike that Act, the Internal Revenue Code does not direct the Secretary of the Treasury to protect or regulate any particular individual or group. The Code simply authorizes him to collect the taxes imposed on the nation as a whole. Thus, the Secretary's decision whether to determine a deficiency in taxes against a particular taxpayer involves the vindication of a governmental interest rather than the protection of rights accorded to an individual.

cution, the Secretary of the Treasury must similarly remain free to make his own legal conclusions as to which organizations are exempt from tax. Accordingly, petitioners should not be able to invoke the jurisdiction of the federal courts to compel the Treasury to adopt and enforce their construction of the term "charitable" in Section 501(c)(3) of the Code.

2. This Court's *Linda R.S.* decision rests upon another ground that equally demonstrates that petitioners lack standing. There, the plaintiff alleged the injury arising from the failure of her child's father to contribute support payments. But the Court observed that "the bare existence of an abstract injury meets only the first half of the standing requirement" (410 U.S. at 618). Although a decision that the statute also applied to the fathers of illegitimate children might have persuaded the father of the plaintiff's child to provide support, the Court concluded that such a prospect could "at best, be termed only speculative" (*ibid.*). The granting of the requested relief would have resulted only in the jailing of the child's father and not his payment of support. Thus, "the 'direct' relationship between the alleged injury and the claim sought to be adjudicated, which previous decisions of this Court suggest is a prerequisite of standing [was] absent in [that] case" (*ibid.*).

Here, too, petitioners have alleged in their complaint a number of instances in which indigent persons have been denied admission to private, tax-exempt hospitals (A. 17-24). They have also alleged

in conclusory terms that the Treasury's recognition of the tax-exempt status of such hospitals has "encouraged" such hospitals to deny their services to the indigent and, that "[a]s a result" of the Treasury's policy, the plaintiffs "have suffered and will continue to suffer injury in their opportunity and ability to receive hospital services * * *" (A. 25). But petitioners have alleged no facts from which it could reasonably be inferred that their injury resulted in any concrete or demonstrable way from the statutory violation they attribute to the Treasury. Indeed, petitioners have made no showing that the relief they seek would result in the admission of a single additional indigent person to a private hospital.[30]

First, nothing in the prior Rev. Rul. 56-185, which required that a tax-exempt hospital "be operated to the extent of its financial ability for those not able to pay * * *," and which petitioners seek to have reinstated, would prevent a private hospital from using its surplus funds for research or capital expenditures rather than for the admission of the

[30] Thus, the district court's conclusion (Pet. App. A 10A) that there was a demonstrable correlation between the Treasury's Revenue Ruling and petitioners' injury is erroneous. A closer examination of the complaint reveals a number of allegations of refusals by hospitals to admit persons eligible for Medicaid assistance (A. 17-18, 21-23). But the very Rev. Rul. 69-545, which petitioners seek to set aside, requires that a hospital admit patients whose care will be paid "with the aid of public programs such as Medicare" (1969-2 Cum. Bull. at 117). Petitioners' complaint would therefore appear to be more appropriately directed to several individual hospitals rather than to the validity of the Ruling policy.

indigent. Second, just as the plaintiff in *Linda R.S.* could not show a connection between prosecution of the father of her child and receipt of support payments, petitioners cannot demonstrate that the revocation or threatened revocation of a hospital's tax-exempt status would coerce it into providing medical care for the indigent. Like the father of the illegitimate child who may prefer to go to jail rather than pay support, a hospital might well elect to forego its tax-exempt status. This is especially true in light of the fact that private philanthropy has declined to only about four percent of the revenue of private hospitals. See American Association of Fund Raising Council, *Giving U.S.A.: 1973*, p. 34.

As the Court stated only last Term in *Warth* v. *Seldin*, No. 73-2024, decided June 25, 1975, in dismissing a similarly defective complaint for lack of standing—"[Petitioners] rely on little more than the remote possibility, unsubstantiated by allegations of fact, that their situation might have been better had respondents acted otherwise, and might improve were the court to afford relief" (slip op. 16). Absent the necessary allegations that the defendants' conduct is harming the plaintiff or threatening him with harm, there is no assurance that "there is a real need to exercise the power of judicial review in order to protect the interests of the complaining party" or that relief can be framed "no broader than required by the precise facts to which the court's ruling would be applied." *Schlesinger* v. *Reservists to Stop the War*, *supra*, 418 U.S. at 221, 222. Since petitioners

have not demonstrated that the Treasury's action has caused their alleged injury, their complaint should likewise have been dismissed.[31]

3. Despite the unprecedented nature of a suit against the Treasury to increase the taxes of persons not parties to the litigation and the absence of any statute creating such a private right of action, petitioners (Br. 49) simply rest their jurisdictional argument upon the "general principle that judicial review of administrative action is the rule and nonreviewability an exception which must be demonstrated by 'clear and convincing evidence' of legislative intent." In support of this proposition, petitioners rely upon various decisions of this Court holding that actions of certain administrative agencies were

[31] Nothing in *Association of Data Processing Service Organizations* v. *Camp*, 397 U.S. 150, relied upon by petitioners (Br. 59), is to the contrary. There, the plaintiffs alleged competitive economic injury to private business enterprise as a result of a ruling by the Comptroller of the Currency permitting national banks to sell data processing services. The Court recognized standing because the claims were "arguably * * * within the zone of interests protected by [Section 4 of the Bank Service Corporation Act, 12 U.S.C. 1861]" (397 U.S. at 156). Thus, that case turned on the fact that Congress had provided for the standing of competitors to maintain such an action. See *United States* v. *Richardson*, *supra*, 418 U.S. at 176, n. 9; *United States* v. *SCRAP*, 412 U.S. 669, 686, n. 13; *Linda R. S.* v. *Richard D.*, *supra*, 410 U.S. at 617, n. 3.

Here, on the other hand, no provision of the Internal Revenue Code creates such a private right of action or a protectable zone of interest. As we have pointed out, *supra*, pp. 27-49, Congress has vested the authority to represent the public interest in the enforcement of the revenue laws exclusively in the Department of the Treasury.

reviewable under the standing provision of Section 10(a) of the Administrative Procedure Act, now 5 U.S.C. 702. That statute provides that "A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof."

However, neither the general principle of judicial review of the Administrative Procedure Act nor the cases cited by petitioners support the proposition that the courts can review the correctness of a Revenue Ruling in an equity suit brought by a person whose own tax liability is not at issue. Each of those cases turned on the Court's particularized inquiry into whether the relevant agency statute had in express or implied terms precluded judicial review or committed the challenged action entirely to administrative discretion. See 5 U.S.C. 701(a).[32] With respect

[32] Thus, for example, in *Barlow* v. *Collins*, 397 U.S. 159, the Court's holding was premised upon its conclusion that Congress intended the agency statute, the Food and Agriculture Act of 1965, to require the Secretary of Agriculture to protect the interests of tenant farmers (397 U.S. at 164), so that the Secretary's issuance of a regulation in derogation of those interests was held to be reviewable. Similarly, in *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 141, the Court's decision rested on its reading of the legislative history of the Food, Drug, and Cosmetics Act indicating that certain review procedures were designed to provide an additional remedy and were not intended to preclude pre-enforcement review of regulations issued by the Commissioner of Food and Drugs. Finally, in *Rusk* v. *Cort*, 369 U.S. 367, 379-380, the Court held that a person outside the United States who was denied a right to citizenship could bring a declaratory judgment action and was

to the administration of the tax laws, Congress has vested exclusive authority in the Secretary of the Treasury and has provided for judicial review of his actions only by persons whose own tax liabilities are at issue.[33] Thus, the Court's decisions with respect to the availability of judicial review of other agency actions under the provisions of other statutes therefore have no bearing on the jurisdictional question presented here.

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not confined to the review procedures of the Immigration and Naturalization Act. Again, the Court's holding was based upon its conclusion that the legislative history demonstrated that the Act's review procedures were applicable to those persons who had chosen to seek admission to the United States in order to prosecute their claim.

[33] Indeed, the Court has not construed the Administrative Procedure Act as requiring judicial review of all agency actions. In certain instances, the Court has held that agency actions were committed to agency discretion by statute within the meaning of the Administrative Procedure Act, 5 U.S.C. 701(a), and are accordingly not reviewable under that Act. See, *e.g.*, *Panama Canal Co.* v. *Grace Line*, 356 U.S. 309, 317; *Schilling* v. *Rogers*, 363 U.S. 666; *Arrow Transportation Co.* v. *Southern R. Co.*, 372 U.S. 658, 667; *Chicago & Southern Air Lines* v. *Waterman S.S. Corp.*, 333 U.S. 103; *United States* v. *Pink*, 315 U.S. 203, 229.

In *Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402, 410, the Court characterized the Administrative Procedure Act's exemption for matters "committed to agency discretion" as "a very narrow exception * * * applicable in those rare instances where 'statutes are drawn in such broad terms that in a given case there is no law to apply.' " The present case, however, is one of those rare instances. Unlike the situation in *Overton Park*, Congress has never prescribed the standards to be employed by the Treasury in determining whether a hospital is a "charitable" organization. See pp. 80-97, *infra*.

C. This Suit Is Barred By The Anti-Injunction And The Declaratory Judgment Acts

Apart from the evidence throughout the Internal Revenue Code that Congress has vested the administration of the tax laws exclusively in the Department of the Treasury so as to preclude suits challenging the tax treatment accorded to other parties, there are two specific statutory prohibitions against this type of equity suit. First, this suit is barred by the federal Anti-Injunction Act. Second, this action is prohibited by the Declaratory Judgment Act, 28 U.S.C. 2201, which bars any declaratory suit "with respect to Federal taxes."

1. *The Anti-Injunction Act.* The Anti-Injunction Act, 26 U.S.C. 7421(a), Appendix A, *infra*, p. 2a, provides with exceptions not here relevant, that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person * * *." The statute was enacted in 1867 [34] in order to prevent the same type of injunctive suit which had swept over the state taxation systems from similarly inundating the federal system. This Court thereafter quickly recognized the congressional policy which underlay the passage of the Act, namely, that if the courts exercised general injunctive power with respect to the collection of taxes, the very existence of government would be threatened. See *State Railroad Tax Cases*, 92 U.S. 575, 613;

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[34] The statute originated as Section 10 of the Act of March 2, 1867, 14 Stat. 475, and is now codified as Section 7421(a) of the Internal Revenue Code of 1954.

Cheatham v. *United States*, 92 U.S. 85, 89; *Snyder* v. *Marks*, 109 U.S. 189, 193-194. The barring of such suits is necessary to enable the Treasury Department effectively to discharge its duty of "superintend[ing] the collection of the revenue * * *" which the First Congress delegated to it. See Act of September 2, 1789, 1 Stat. 65, Section 2. This includes a wide variety of administrative acts, including the acceptance of tax returns for filing, audits of returns, and promulgation of Regulations and Revenue Rulings.

Recently, in *Bob Jones University* v. *Simon*, 416 U.S. 725, the Court reaffirmed the specific prohibition of the Anti-Injunction Act against equity suits interfering with the process of collecting taxes. There, a tax-exempt organization brought suit to enjoin the Commissioner's revocation of its exempt status. In holding that such a claim was barred by the Act, the Court stated that the language of the statute—"no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court * * *"—"could scarcely be more explicit" (416 U.S. at 736). As the Court pointed out (*id.* at 742), this literal reading of the Act was consistent with its earlier decisions during the first half century of the Act's existence, which applied the broad prohibition without regard to the character of the tax, the nature of the challenge, or the effect of collection upon the taxpayer. See *Snyder* v. *Marks*, *supra*; *Pacific Steam Whaling Co.* v. *United States*, 187 U.S. 447; *Dodge* v. *Osborn*, 240 U.S. 118.

The court of appeals held that the bar of the Anti-Injunction Act was not applicable to this case because petitioners do not seek to restrain the "assessment or collection" of any tax but rather seek to increase the amount of taxes which would be paid by any hospital which does not provide a full range of medical services for the indigent. But this ruling ignores this Court's statement in *State Railroad Tax Cases*, *supra*, 92 U.S. at 613, that the Act was intended to prevent judicial interference "with the *process* of collecting the taxes on which the government depends for its continued existence" (emphasis supplied). The "process" of tax collection by the Department of the Treasury includes the making of administrative determinations such as the Revenue Ruling at issue here. As the Tenth Circuit recently held in *Cattle Feeders Tax Committee* v. *Shultz*, 504 F.2d 462, the Anti-Injunction Act bars any suit by a nontaxpayer to enjoin the promulgation of Revenue Rulings which would affect the tax liability of others.

Moreover, the word "restrain" in the Anti-Injunction Act does not necessarily limit the Act's application to those suits seeking to "lower" or "reduce" tax collections, as petitioners contend (Br. 50-51). That term means "to limit or restrict to * * * a particular action or course * * *." See Webster's Third New International Dictionary, p. 1936. Since petitioners seek to limit the Commissioner's policy regarding the tax-exempt status of hospitals to the test promulgated in the prior Rev. Rul. 56-185, they do in fact seek to "restrain" the assessment and collec-

tion of taxes within the meaning of the Anti-Injunction Act.[35]

Indeed, the broad type of equitable relief which petitioners seek in this action is even more threatening to the orderly administration of the revenue laws than injunctive actions by taxpayers with respect to their own liabilities. While an injunctive action brought by an individual taxpayer attempts to affect the assessment and collection of his taxes alone, this suit seeks to alter a ruling of general application which would affect both the tax-exempt status of all private hospitals and their contributors. If the courts regularly entertained such challenges to the correctness of Revenue Rulings, by persons whose own tax liabilities were not at issue, it can hardly be doubted that the Treasury's activities in other more fruitful areas of enforcement would have to be curtailed, to the detriment of the revenue collections. See *Moore* v. *Miller*, 5 App. D.C. 413, 419, appeal dismissed, 163 U.S. 696.

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[35] In certain instances this suit, which seeks the imposition of a more stringent exemption standard, could decrease the tax liability of hospitals. Under Sections 512 and 513 of the Code, tax-exempt hospitals are not permitted to offset exempt function losses against taxable unrelated business income, such as from a pharmacy serving non-patients. See Rev. Rul. 68-375, 1968-2 Cum. Bull. 245, and Rev. Rul. 68-376, 1968-2 Cum. Bull. 246. Thus, if a hospital had exempt function losses and taxable unrelated business income and it lost its exemption as a result of this suit, its tax liability could be decreased because its otherwise nondeductible exempt function losses could then be used to offset all of its income. See Comment, 54 Va. L. Rev. 1532, 1548-1550 (1968).

It would be anomalous to impute to Congress the intent to bar injunctive actions by taxpayers who are directly affected by the collection of their tax liability but to permit nontaxpayers whose interests are far more tangential to enjoin the administrative determinations of the Treasury and thereby affect the tax liabilities of countless numbers of taxpayers. The prohibition of the Anti-Injunction Act against judicial interference with the actions of the tax collector should apply to both taxpayer and nontaxpayer alike.[36]

2. *The Declaratory Judgment Act.* This suit is also barred by the Declaratory Judgment Act, 28 U.S.C. 2201 (Appendix A, *infra*, p. 3a), which bars any declaratory suit "with respect to Federal taxes." Section 2202 expands this prohibition by providing that the statute applies to any "[f]urther necessary or proper relief based upon a declaratory judgment or decree * * *." The latter provision encompasses injunctions in aid of the declaration of rights, as well as the declaration itself. S. Rep. No. 1005, 73d Cong., 2d Sess. 6 (1934). Since petitioners seek a declaration as to the future tax liabilities of all hos-

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[36] Only Congress can modify the statutory proscription against nontaxpayer equity suits against the Internal Revenue Service. Thus, for example, Congress has recently enacted a statute, incorporated as Section 7476 of the Internal Revenue Code, allowing the Pension Benefit Guarantee Corporation, employees, plan administrators, and employers to obtain declaratory judgments in the Tax Court with respect to qualifications of pension plans. The statute also permits intervention by the Secretary of Labor. See H.R. Conf. Rep. No. 93-1280, 93d Cong., 2d Sess. 331-332 (1974).

pitals that do not provide a full range of medical services for the indigent, and the future tax liabilities of the contributors to such hospitals, together with an injunction in support of the declaration, the relief they seek is barred by the express terms of the tax exception to the Declaratory Judgment Act, regardless of the application of the Anti-Injunction Act.

In *Bob Jones University* v. *Simon*, *supra*, 416 U.S. at 732-733, n. 7, this Court did not resolve the question whether the tax exception of the Declaratory Judgment Act has a broader reach than the Anti-Injunction Act. The court of appeals therefore felt free to follow its previous decision in *"Americans United" Inc.* v. *Walters*, 477 F.2d 1169 C.A. D.C.), reversed on other grounds *sub nom. Alexander* v. *"Americans United," Inc.*, 416 U.S. 752, and refused to give the Declaratory Judgment Act any significance independent of the Anti-Injunction Act, reasoning that the two statutes "were intended to be coterminous" (Pet. App. B 42A-43A). We submit that the conclusion of the court of appeals fails to give meaning to the words of the Declaratory Judgment Act and its legislative history and departs from or misreads the applicable precedents.

The tax exemption to the Declaratory Judgment Act was placed in the statute about one year after its original enactment.[37] It was inserted in response to a flood of suits declaring the "processing" taxes

[37] The amendment was contained in Section 405 of the Revenue Act of 1935, 49 Stat. 1027.

unconstitutional or inapplicable. See Borchard, *Declaratory Judgments* (1941 ed.) 850-857. The Senate Report on the prohibitory amendment noted that these cases represented a departure from precedents under the Anti-Injunction Act, and that it was necessary to preserve tax "determination[s]," as well as assessments and collections, free of judicial interference apart from the statutory review system (S. Rep. No. 1240, 74th Cong., 1st Sess., Part 1, 11 (1935):

> Your committee has added an amendment making it clear that the Federal Declaratory Judgments Act of June 14, 1934, has *no application to Federal taxes*. The application of the Declaratory Judgments Act to taxes would constitute a *radical departure* from the long-continued policy of Congress (as expressed in Rev. Stat. 3224 and other provisions) with respect to the determination, assessment, and collection of Federal taxes. Your committee believes that *the orderly and prompt determination and collection of Federal taxes should not be interfered with* by a procedure designed to facilitate the settlement of private controversies, and that *existing procedure both in the Board of Tax Appeals and the courts afford ample remedies for the correction of tax errors*. [Emphasis supplied.]

Thus, even assuming, *arguendo*, that the phrase "assessment and collection" in the Anti-Injunction Act does not encompass petitioners' attempt to obtain a judicial declaration as to the tax liabilities of various hospitals and their contributors, this case

nevertheless falls within the broader statutory phrase "with respect to Federal taxes" of 28 U.S.C. 2201 and concerns the "determination" of federal taxes, within the meaning of the Senate Committee's use of that term. See Bittker and Kaufman, *Taxes and Civil Rights: "Constitutionalizing" the Internal Revenue Code*, 82 Yale L. J. 51, 58 (1972). Indeed, the leading commentator on the Declaratory Judgment Act has acknowledged that the tax exception was based upon a broad rationale which "denies the possibility of challenging federal taxes of any kind on any ground by declaratory action." Borchard, *supra*, at 855.[38]

The decisions of the lower federal courts have applied the Declaratory Judgment Act prohibition to nontaxpayer suits respecting the federal tax liabilities of other parties in circumstances analogous to those presented here. Thus, for example, in *Liberty Amendment Committee of the U.S.A.* v. *United States* (No. 70-721-HP, C.D. Cal.), affirmed *per curiam* (No. 26,507, C.A. 9), certiorari denied, 409 U.S. 1076, the court held that the Declaratory Judgment Act barred an organization exempt from tax under Section 501(c)(4) from obtaining injunctive relief requiring the Treasury Department to

[38] The tax exception to the Declaratory Judgment Act was enacted at the request of the Department of Justice to exclude from the scope of the Act "all actions involving 'federal taxes.'" Borchard, *supra*, at 850. Assistant Attorney General Wideman told the Senate Finance Committee "that Congress intended to apply the Act to matters of private law" and that "tax matters were intended to be excluded" (*ibid.*).

issue a ruling recognizing its eligibility for tax deductible contributions under Section 170(c)(2) and tax-exempt status under Section 501(c)(3). See also *Jolles Foundation* v. *Moysey*, 250 F.2d 166 (C.A. 2); *Bob Jones University* v. *Simon*, *supra*, 416 U.S. at 734, n. 8.

In holding (Pet. App. B 42A-43A) that the tax exception to the Declaratory Judgment Act was "coterminous" with the Anti-Injunction Act, the court of appeals relied upon its prior decision in *"Americans United" Inc.* v. *Walters*, 477 F.2d 1169 (C.A. D.C.), reversed on other grounds *sub nom. Alexander* v. *"Americans United," Inc.* 416 U.S. 752, which in turn relied upon a line of cases beginning with *Tomlinson* v. *Smith*, 128 F.2d 808, 811 (C.A. 7), and followed most recently in *McGlotten* v. *Connally*, 338 F. Supp. 448, 452-453 (D. D.C.).[39] But the *Tomlinson* case and most of its progeny actually support a contrary conclusion.

[39] In *McGlotten*, a three-judge district court ordered the Treasury to revoke the tax-exempt status of a fraternal organization with racially discriminatory membership policies. A motion to dismiss on account of mootness is currently pending. See also *Green* v. *Kennedy*, 309 F. Supp. 1127 (D. D.C.), continued *sub nom. Green* v. *Connally*, 330 F. Supp. 1150 (D. D.C.), affirmed *sub nom. Coit* v. *Green*, 404 U.S. 997 (injunction against Secretary of the Treasury requiring it to adhere to its revised policy refusing to recognize the exempt status of racially discriminatory private schools). Because the Secretary of the Treasury had already changed his policy, he did not appeal the injunction order and the appeal was taken by the intervenors on the merits. In *Bob Jones University* v. *Simon*, *supra*, 416 U.S. at 740, n. 11, the Court indicated that its affirmance in *Coit* lacked full precedential weight.

In *Tomlinson*, a nontaxpayer third-party—a trustee of partnership property—sought injunctive and declaratory relief preventing the Commissioner from levying on partnership property to satisfy the tax liability of another taxpayer, *i.e.*, the plaintiff in his capacity as an individual partner. The court initially held that the Anti-Injunction and the Declaratory Judgment Acts were "co-extensive" in the sense that they did not prohibit suits by nontaxpayers to enjoin levies on their property to satisfy the tax liabilities of other taxpayers. That holding is now codified in Section 7426 of the Internal Revenue Code.[40]

[40] Petitioners argue (Br. 56) that the enactment of Section 7426 of the Code to permit suits by nontaxpayers against the imposition of tax liens on their property and the concomitant modification of the Anti-Injunction Act to take account of this exception demonstrates that the two statutes are coterminous. They suggest that if the Declaratory Judgment Act were broader than the Anti-Injunction Act the additional phrase in the Anti-Injunction Act—"by any person, whether or not such person is the person against whom such tax was assessed"—would not have been necessary.

No such inference can be drawn from the added phrase in Section 7421 and by the amendment to the Anti-Injunction Act. The problem addressed by Section 7326—nontaxpayer suits to enjoin levies on their property to satisfy the tax liabilities of other taxpayers—was generally regarded by the courts as involving property law and not revenue laws. See *Long* v. *Rasmussen*, 281 Fed. 236 (D. Mont.). Thus, such suits were not believed to be within the bar of either the Anti-Injunction Act of Declaratory Judgment Act. It was thought appropriate to place the additional phrase in Section 7421(a) to insure that apart from the narrow Section 7426 exception, Section 7421 would continue to bar injunctive actions by nontaxpayers in the non-revenue property law cases.

Petitioners also contend (Br. 56) that the additional phrase

The court went on to hold, however, that the nontaxpayer plaintiff's attempt to obtain a declaration as to the tax liability of the taxpayer was barred by the tax exception to the Declaratory Judgment Act. The same distinction was made in *Bullock* v. *Latham*, 306 F.2d 45 (C.A. 2), and in *Jules Hairstylists of Maryland* v. *United States*, 268 F. Supp. 511, 515 (D. Md.), affirmed *per curiam*, 389 F.2d 389 (C.A. 4), certiorari denied, 391 U.S. 934, upon which the *McGlotten* opinion (338 F. Supp. at 543, n. 23) relied.[41] Petitioners' attempt to obtain a ju-

in Section 7421 "against whom such tax was assessed," confirms that Section 7421 was never intended to apply to nonassessed parties such as themselves. However, the exception of *Long* v. *Rasmussen, supra*, to Section 7421 turned partially on whether taxes had been assessed against the plaintiff. Thus, the added statutory phrase in Section 7421 used the term "assess" because it was addressed to, and designed to close, the *Long* exception unless Section 7426 applied. The use of that term in treating the *Long* property law situation does not mean that Section 7421 did not previously apply to nonassessed plaintiffs in other situations such as in this case. See, *e.g.*, *Gardner* v. *Helvering*, 88 F.2d 746 (C.A. D.C.). See also *Bob Jones University* v. *Simon, supra*, 416 U.S. at 731-732, n. 6.

[41] Other cases barring suits by nontaxpayers respecting the tax liabilities of other taxpayers on the basis of the Declaratory Judgment Act include: *Singleton* v. *Mathis*, 284 F.2d 616 (C.A. 8) (suit by gambling machine lessor respecting tax liability of lessee); *Mitchell* v. *Riddell*, 402 F.2d 842 (C.A. 9), appeal dismissed and certiorari denied, 394 U.S. 456 (suit by trust grantor respecting exemption from trust income taxes); *West Chester Feed & Supply Co.* v. *Erwin*, 438 F.2d 929 (C.A. 6); and *In re Wingreen Co.*, 412 F.2d 1048 (C.A. 5) (suits by bankruptcy trustee respecting tax liability of the bankrupt).

dicial declaration concerning the tax liabilities of other parties is therefore similarly barred by the "tax exception" to the Declaratory Judgment Act.

D. This Action Constitutes An Unconsented Suit Against The United States And Is Barred By Sovereign Immunity

Petitioners' complaint should have been dismissed for the additional reason that it is an unconsented suit against the United States.

1. This Court has on many occasions reaffirmed the general rule that a suit is against the sovereign if "the judgment sought would expend itself on the public treasury or domain, or interfere with the public administration," *Land* v. *Dollar*, 330 U.S. 731, 738, or if the effect of the judgment would be "to restrain the Government from acting, or to compel it to act," *Larson* v. *Domestic & Foreign Corp.*, 337 U.S. 682, 704; *Dugan* v. *Rank*, 372 U.S. 609, 620. Although the named defendants are the Secretary of the Treasury and the Commissioner of Internal Revenue, "it has long been established that the crucial question is whether the relief sought in a suit nominally addressed to the officer is relief against the sovereign," *Larson* v. *Domestic & Foreign Corp.*, *supra*, 337 U.S. at 687.[42]

[42] Pursuant to those authorities, the court below had previously held in *Reisman* v. *Caplin*, 317 F.2d 123, 125 (C.A. D.C.), affirmed on other grounds, 375 U.S. 440, that sovereign immunity barred an injunctive action by nontaxpayers seeking to enjoin a tax audit that would allegedly injure the plaintiffs.

Here, petitioners seek to compel the Secretary of the Treasury and the Commissioner of Internal Revenue to revoke an outstanding Revenue Ruling, to reinstate a prior Revenue Ruling, to revoke the exempt status of hospitals that do not furnish free care to the indigent, to prohibit the future recognition of such hospitals as tax-exempt organizations, and to collect taxes from such hospitals to the extent they are owing. Petitioners are not suing the named defendants in their individual capacities but are seeking to require them to perform certain actions in their official capacities as administrators of the federal tax laws. Thus, the suit is against the sovereign under the standard of *Hawaii* v. *Gordon*, 373 U.S. 57, because "the order requested would require the * * * [Secretary's] official affirmative action, [and] affect the public administration of government agencies" (*id.* at 58).

Indeed, the nature of the claim of the plaintiff in *Hawaii* v. *Gordon*, was similar to that of petitioners. That case was an original action by the State of Hawaii against the Director of the Bureau of the Budget challenging his interpretation of the Hawaii Statehood Act. The Act provided for the transfer by the United States to Hawaii of lands that the United States no longer needed. The Director held, on the basis of an opinion of the Attorney General, that this provision applied only to lands originally ceded by Hawaii to the United States or lands obtained for exchange of such lands, and not to lands obtained by the United States by purchase,

gift or condemnation, and so advised other federal agencies.

The Court dismissed the suit on the ground that it was an unconsented suit against the United States. Like petitioners who seek an order compelling the Commissioner of Internal Revenue to withdraw his published legal opinion, Hawaii's suit sought an order requiring the Director "to withdraw this advice to the federal agencies, determine whether a certain 203 acres of land in Hawaii acquired by the United States through condemnation was land or properties 'needed by the United States' and, if not needed, to convey this land to Hawaii" (373 U.S. at 58).

2. The court of appeals concluded (Pet. App. B 38A-39A) that sovereign immunity did not bar this action because: (a) petitioners were challenging the authority of the Commissioner of Internal Revenue to interpret a revenue statute in a manner contrary to established congressional policy, and (b) the Administrative Procedure Act constitutes a waiver of sovereign immunity. Both of these grounds are erroneous.

(a) In *Larson* v. *Domestic & Foreign Corp.*, *supra*, 337 U.S. at 689-690, this Court recognized that suits against officers of the sovereign are not suits against the sovereign if the officer allegedly has acted beyond his statutory powers or if the statute under which he acts is alleged to be unconstitutional. In both of those instances, the conduct complained of is not in fact governmental so that the bar of sovereign immunity cannot be invoked.

Neither exception is applicable to this case. Petitioners do not complain that the Secretary or the Commissioner acted unconstitutionally[43] or beyond their statutory powers. In fact, the court of appeals recognized (Pet. App. B 39A), and petitioners have never questioned, the authority of the Commissioner to issue rulings to private organizations regarding their tax-exempt status. Cf. Section 508(a) of the Code. Thus, petitioners' claim is only a contention that the Commissioner has made an erroneous interpretation of the term "charitable" in Section 501 (c)(3) of the Code.

Accordingly, this case falls within the well-established rule that an Executive official's performance of a statutory duty to interpret the law is an action of the sovereign which the courts may not enjoin unless Congress has consented to such a suit. See, *e.g.*, *Hawaii* v. *Gordon*, 373 U.S. 57; *Dugan* v. *Rank*, 372 U.S. 609, 621-622; *Malone* v. *Bowdoin*, 369 U.S. 643; *Larson* v. *Domestic & Foreign Corp.*, *supra*, 337 U.S. at 689-690.

This Court has recognized that Treasury officials are immune from suit challenging their interpretation of the federal tax statutes unless pursuant to specific statutory authorization. As we have pointed out, *supra*, pp. 45-46, *Louisiana* v. *McAdoo*, 234 U.S. 627, held that a suit to declare illegal the Treasury's interpretation of a tax statute must be dismissed even though the particular circumstances would have made

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[43] *Georgia R. Co.* v. *Redwine*, 342 U.S. 299, relied upon by petitioners (Br. 58), involved a claim of unconstitutionality of a state tax and is therefore distinguishable.

it impossible for the plaintiff to obtain judicial review by means of a refund suit or through other procedures. The Court expressed particular concern at the fact that there, as here, the suit was brought by a party whose principal interest was other than his own tax liabilities (234 U.S. at 632):

> Obviously such suits to review the official action of the Secretary of the Treasury in the exercise of his judgment as to the rate which should be exacted under his construction of the * * * [taxing statute] would operate to disturb the whole revenue system of the Government and affect the revenues which arise therefrom. *Such suits would obviously, in effect, be suits against the United States.* [Emphasis supplied.]

Accord: *Jr. C. of C., Rochester, Inc., N.Y.* v. *U.S. Jaycees, Tulsa, Okla.*, 495 F.2d 883, 888-889 (C.A. 10), certiorari denied *sub nom. Junior Chamber of Commerce of Philadelphia* v. *United States Jaycees*, 419 U.S. 1026 (sovereign immunity barred suit by womens' rights group to compel revocation of organization's tax exemption on ground that it excluded women from membership).[44]

[44] There is no record that any Revenue Ruling was ever reviewed by the courts during the nineteenth century. In the earliest days of the Republic, taxpayers were allowed little judicial review of any actions of revenue officials in assessing and collecting taxes. Thus, for example, in 1836, this Court held that a taxpayer might bring an action in the nature of assumpsit against an individual collector for a refund of taxes erroneously collected. *Elliott* v. *Swartwout*, 10 Pet. 137. In 1838, however, Congress enacted legislation providing that all taxes paid to collectors under protest should be remitted promptly to the Treasury without awaiting the result of any

litigation. Act of March 3, 1839, 5 Stat. 348, Section 2. In *Cary* v. *Curtis*, 3 How. 236, 244, this Court noted the government's immunity from suit in holding that the Act of March 3, 1839, had effectively prohibited all assumpsit suits for refund against collectors. The only remaining procedure by which a taxpayer could obtain judicial review of an alleged over-assessment at that time was to post a bond for payment and then litigate liability for the taxes when the government brought suit on the bond. See *Cary* v. *Curtis, supra*, 3 How. at 243; *Ex parte Davenport*, 6 Pet. 661; *United States* v. *Phelps*, 8 Pet. 700. These suits were the predecessor of the modern collection suit, in which liability for the tax may be challenged by the taxpayer. See, *e.g., United States* v. *Rexach*, 482 F.2d 10 (C.A. 1), certiorari denied, 414 U.S. 1039.

Even after Congress provided by statute for refund suits against the collectors (*e.g.*, Act of February 26, 1845, 5 Stat. 727), the courts were extremely strict in requiring exact compliance with the statutory requirements for bringing these suits, and in barring non-complying litigants on sovereign immunity grounds. Thus, in *Nichols* v. *United States*, 7 Wall. 122, 126, the Court held that a taxpayer who had failed to make the required formal protest to the Treasury was barred by sovereign immunity from seeking a tax refund in a Court of Claims action. Cf. *Kings County Savings Institution* v. *Blair*, 116 U.S. 200, 205-206; *Smietanka* v. *Indiana Steel Co.*, 257 U.S. 1; *Lowe Bros. Co.* v. *United States*, 304 U.S. 302, 306; *United States* v. *Garbutt Oil Co.*, 302 U.S. 528, 533-535.

It was not until the Act of July 30, 1954, 68 Stat. 589, that taxpayers were unconditionally allowed to bring suits against the United States for refund in the district courts without limitation as to amount involved and with full right to jury trial. See H.R. Rep. No. 659, 83d Cong., 1st Sess. (1953); H.R. Conf. Rep. No. 2276, 83d Cong., 2d Sess. (1954). See also Plumb, *Tax Refund Suits Against Collectors of Internal Revenue*, 60 Harv. L. Rev. 685 (1947). In addition, Congress has given its consent to taxpayers' suits in the Tax Court for adjudications respecting asserted deficiencies in proposed tax assessments. Section 274 of the Revenue Act of 1924, 43 Stat. 297; see, currently, Sections 6212 and 6213 of the 1954 Code. Apart from these procedures, and with the exception of Section 7426 which is not relevant here, Congress

(b) The second reason of the court of appeals—that the viability of the sovereign immunity doctrine is open to question after the enactment of the Administrative Procedure Act in 1946 (Pet. App. B 37A-38A)—is equally erroneous. The Administrative Procedure Act does not waive the United States' sovereign immunity. Six courts of appeals have so held. *Littell* v. *Morton*, 445 F.2d 1207, 1212 (C.A. 4); *State of Washington* v. *Udall*, 417 F.2d 1310, 1320 (C.A. 9); *Zimmerman* v. *United States Government*, 422 F.2d 326, 330-332 (C.A. 3); *Motah* v. *United States*, 402 F.2d 1, 2 (C.A. 10); *Twin Cities Chippewa Tribal Council* v. *Minnesota Chippewa Tribe*, 370 F.2d 529, 532 (C.A. 8); and *Cyrus* v. *United States*, 226 F.2d 416 (C.A. 1).[45] Three circuits, including the court below, have taken the contrary view. *Scanwell Laboratories, Inc.* v. *Shaffer*, 424 F.2d 859, 873-874 (C.A. D.C.); *Estrada* v. *Ahrens*, 296 F.2d 690 (C.A. 5); and *Kletschka* v. *Driver*, 411 F.2d 436, 445 (C.A. 2) (alternative ground for decision).[46] Compare, however, *Warner* v. *Cox*, 487 F.2d 1301 (C.A. 5); *Colson* v. *Hickel*, 428 F.2d 1046 (C.A. 5); and *Ortego* v. *Weinberger*, C.A. 5, No. 74-3048, decided August 11, 1975, slip op. 6803-6808.

has not consented to suit of the Treasury by either taxpayers or nontaxpayers with respect to the assessment or collection of taxes.

[45] In *Littell* and *State of Washington*, however, the courts held sovereign immunity inapplicable because they concluded that the interests served by judicial review in the particular cases outweighed the interests served by sovereign immunity, even though both actions sought to affect a disposition of sovereign property. See 445 F.2d at 1213-1214; 417 F.2d at 1320. *Littell* involved a claim for legal fees for services rendered. *State of Washington* involved a claim that certain water should be made available to the State without legal restrictions by the federal government. However, if the suit is against the sovereign, only Congress can waive immunity, and the courts cannot decide to entertain such suits based upon their evaluation of the relative interests to be served by judicial review in the particular case. At all events, the present action, involving a challenge to the Secretary of the Treasury's exclusive authority to administer the revenue laws, involves wholly different considerations.

The cases holding that the Administrative Procedure Act waived sovereign immunity rely upon Section 10(a) of that Act, now 5 U.S.C. 702, which provides: "A person * * * adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof." This section does not deal with jurisdiction, however, but only with standing. The provision dealing with jurisdiction, Section 10(b), now 5 U.S.C. 703, states that the "form of proceeding for judicial review is * * * any applicable form of legal action * * * *in a court of competent jurisdiction*" (emphasis supplied).

The Administrative Procedure Act does not of itself confer jurisdiction, but only prescribes the procedures for administrative review for courts having

[46] But see *Divonne* v. *Internal Revenue Service*, 75-2 U.S.T.C., par. 9619 (S.D. N.Y., July 16, 1975), holding that the judicial review provisions of the Administrative Procedure Act did not waive sovereign immunity in a suit by a tax informer to obtain a reward, since the allowance of such reward was "committed to agency discretion by law" under 5 U.S.C. 701(a)(1), citing the *Kletchka* decision.

jurisdiction. Since sovereign immunity is a jurisdictional issue, the Administrative Procedure Act did not waive it. As this Court said of that Act in *Blackmar* v. *Guerre*, 342 U.S. 512, 515-516, "[s]till less is the Act to be deemed an implied waiver of all governmental immunity from suit."

Thus, viewed from an historical perspective, the purpose and effect of both the sovereign immunity principle and the Anti-Injunction and Declaratory Judgment Acts are to prevent the type of disturbance of the revenue system to which the Court referred in *Louisiana* v. *McAdoo*, *supra*. Taken together, sovereign immunity and the statutory proscriptions serve to restrict judicial review of revenue administration to the statutory system composed of refund and Tax Court and deficiency proceedings. The decision of the court of appeals would extend judicial review to many revenue administrative acts of a wholly different character. If there is to be such an extension of judicial review in the vital area of the administration of the nation's revenue laws, it should be done by Congress, not by the courts.[47]

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[47] Although petitioners dismiss as "utter nonsense" (Br. 62) the possibility that equity suits by nontaxpayers against the Treasury would burden the courts, the number of such suits which have been brought in recent years is in fact quite substantial. See, *e.g.*, *United States* v. *American Friends Service Committee*, 419 U.S. 7 (Anti-Injunction Act barred suit by Quaker organization to enjoin enforcement of withholding tax on its employees); *Cattle Feeders Tax Committee* v. *Shultz*, 504 F.2d 462 (C.A. 10) (Anti-Injunction Act barred suit by nontaxpayer organization to enjoin enforcement of Revenue Ruling relating to deductibility of prepaid cattle feed); *Jr. C. of C., Rochester, Inc., N.Y.* v. *U.S. Jaycees,*

Tulsa, Okla., 495 F.2d 883 (C.A. 10), certiorari denied *sub nom. Junior Chamber of Commerce of Philadelphia* v. *United States*, 419 U.S. 1026 (suit to compel revocation of organization's tax exemption on ground that it excluded women from membership barred by sovereign immunity). See, also, *McCoy* v. *Shultz*, 73-1 U.S.T.C., par. 9233 (D. D.C., February 13, 1973); *Marker* v. *Connally*, 337 F. Supp. 1301 (D. D.C.), affirmed *sub nom. Marker* v. *Shultz*, 485 F.2d 1003 (C.A. D.C.) (ruling for government on merits of suit by dissenting union members to compel Treasury to revoke exempt status of labor union engaged in certain political activities).

Other cases are as follows: *Greenhouse* v. *Most Reverend Charles Pascal Greco* (C.A. 5—No. 75-2050) (appeal from denial of class action and dismissal of suit by black plaintiffs to require revocation of tax exemptions of certain parochial schools because of alleged racial discrimination); *American Society of Travel Agents* v. *Simon* (D. D.C.—Civ. No. 74-1081) (dismissal of suit to compel revocation of exempt status and/or to impose unrelated business tax upon organizations alleged to be substantially involved in travel programs); *Tax Analysts and Advocates* v. *Simon* (D. D.C.—Civ. No. 74-1898) (dismissal for mootness of suit challenging the validity of gift tax ruling affecting political contributions); *Tax Analysts and Advocates, et al.* v. *Simon* (C.A. D.C.—Civ. No. 75-1304) (appeal from dismissal for lack of standing of action seeking revocation of rulings relating to the foreign tax credit allowed international oil companies); *International Telephone and Telegraph Co.* v. *Commissioner* (D. Del—Civ. No. 74-70) (Anti-Injunction and Declaratory Judgment Acts barred suit by corporation seeking revocation of ruling relating to tax consequences of transaction upon its shareholders); *State of Minnesota* v. *United States* (C.A. 7—No. 74-1973) (appeal from dismissal under Anti-Injunction Act of suit to enjoin assessment of federal telephone excise tax); *Common Cause* v. *Connally* (D. D.C.—Civ. No. 1337-71) (suit which sought to enjoin enforcement of Treasury Regulations relating to depreciation guidelines dismissed as moot by agreement); *Rivera* v. *Weinberger* (W.D. Mich.—No. K-74-236CA3) (motion to dismiss denied in suit by migrant farm workers to require the Internal Revenue Service to audit farmers to assist plaintiffs in obtaining Social Security cards).

[Footnote continued on page 80]

If the Court agrees with the foregoing argument that the courts below had no jurisdiction to entertain this action, the judgment of the court of appeals should be reversed and the case should be remanded to the district court with directions to dismiss the complaint for lack of jurisdiction. If, however, the Court disagrees with our submission, it will then have to consider the questions presented in No. 74-1110 relating to the correctness of the Revenue Ruling and the applicability of the notice and hearing requirements of the Administrative Procedure Act to its promulgation—which we now discuss.

II. THE SECRETARY'S REVENUE RULING THAT A HOSPITAL IS ENTITLED TO EXEMPTION FROM TAXES IF IT FURNISHES EMERGENCY CARE FOR ALL PERSONS REGARDLESS OF THEIR ABILITY TO PAY CORRECTLY INTERPRETS THE TERM "CHARITABLE" IN SECTION 501(c)(3) OF THE CODE

1. Section 501(c)(3) of the Internal Revenue Code of 1954, exempts from taxation—

[47] [Continued]

Finally, in the following cases, no jurisdictional opinions or judgments have yet been entered: *Jackson* v. *Statler Foundation* (D. D.C.—Civ. No. 74-499) (suit to require revocation of tax exemption because of taxpayer's alleged racial discrimination); *Alexander* v. *N.F.O.* (W.D. Mo.—Civ. No. 1919-1) (suit to require revocation of tax exemption of competitors because of latter's alleged violations of antitrust laws); *Lugo* v. *Simon* (N.D. Ohio—No. C74-345) (suit by indigent plaintiffs to obtain revocation of Rev. Rul. 69-545 at issue in this case).

> Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual * * *.

This provision has its roots in Section 32 of the Act of August 27, 1894, 28 Stat. 556, which exempted "corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes * * *." A similar exemption was included in the corporate income tax enacted in 1909. See Act of August 5, 1909, 36 Stat. 113, Section 38. At no time, however, did Congress attempt to define "charitable." The scope of the statutory term "charitable" was left for the Secretary of the Treasury to define in his administration of the tax laws.

To the extent that Congress considered the definition of "charitable," it was extremely broad. As the sponsor of the 1909 exemption provision stated, the exemption extended to those organizations "devoted exclusively to the relief of suffering, to the alleviation of our people, and to all things which commend themselves to every charitable and just impulse" (44 Cong. Rec. 4150 (1909)).

Pursuant to his authority under Section 7805(a) of the Code to "prescribe all needful rules and regulations," the Commissioner of Internal Revenue, on February 26, 1959, issued proposed new Regulations under Section 501(c)(3) of the Code. After consideration of presentations by interested persons at hear-

ings, the Commissioner promulgated the Regulations in final form on June 22, 1959.[48] In pertinent part, Section 1.501(c)(3)-1(d)(2) of the Regulations defined the statutory term "charitable" as follows:

> (2) *Charitable defined.* The term "charitable" is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions. Such term includes: Relief of the poor and distressed or of the underprivileged; advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human and civil rights secured by law; or (iv) to combat community deterioration and juvenile delinquency. The fact that an organization which is organized and operated for the relief of indigent persons may receive voluntary contributions from the persons intended to be relieved will not necessarily prevent such organizations from being exempt as an organization organized

[48] See T.D. 6391, 1959-2 Cum. Bull. 139-146; 24 Fed. Reg. 5217, 5219. The proposed regulations and the final Regulations were identical with respect to the definition of "charitable." See 24 Fed. Reg. 1421, 1423.

> and operated exclusively for charitable purposes.

Prior to the 1959 amendment, the Regulations did not contain a comprehensive definition of the term "charitable." Rather, the previously outstanding regulation (Treasury Regulations 118, Section 39.101(6)-1(b)) under the 1939 Code stated:

> Corporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor. The fact that a corporation established for the relief of indigent persons may receive voluntary contributions from the persons intended to be relieved will not necessarily deprive it of exemption.

Petitioners do not challenge the definition of "charitable" in the currently outstanding Section 1.501(c)(3)-1(d)(2) of the Regulations. Indeed, such challenge would be unlikely to succeed, given the long-standing decisions of this Court that Treasury Regulations are "contemporaneous constructions by those charged with administration" of the Code which "must be sustained unless unreasonable and plainly inconsistent with the revenue statutes" and "should not be overruled except for weighty reasons." *Commissioner* v. *South Texas Co.*, 333 U.S. 496, 501. See also *Fawcus Machine Co.* v. *United States*, 282 U.S. 375; *Bingler* v. *Johnson*, 394 U.S. 741, 749-750. Nor do petitioners question the Commissioner's authority to modify the Regulations. Any such argument would likewise fail in light of the settled rule that even Treasury Regulations approved by Con-

gress may be changed by the Secretary pursuant to his broad power under Section 7805(a) of the Code. See, *e.g.*, *Helvering* v. *Reynolds*, 313 U.S. 428, 432; *Helvering* v. *Wilshire Oil Co.*, 308 U.S. 90, 101; *Morrissey* v. *Commissioner*, 296 U.S. 344.

Petitioners argue (Br. 40) that the Commissioner's current ruling governing the tax-exempt status of private hospitals is contrary to the "judicial, administrative, and legislative history of the application of 'charitable' under sections 501(c)(3) and 170(c) * * *" and has thereby "amend[ed] the Code" (Br. 39). Specifically, petitioners' complaint concerns the modification of Rev. Rul. 56-185, in which the Commissioner concluded that in order to qualify as a "charitable" organization, a hospital had to "be operated to the extent of its financial ability for those not able * * * and expected to pay." Subsequently, in Rev. Rul. 69-545, the Commissioner modified his ruling announced in 1956, and held that a hospital would be recognized as tax exempt if, *inter alia*, it promoted the health of a class of persons broad enough to benefit the community as a whole by maintaining an emergency room open to all persons regardless of ability to pay and by providing hospital care to all persons able to pay either themselves or through private insurance or public assistance.

It is settled that the Commissioner is empowered to alter his legal position set forth in published Revenue Rulings. See, *e.g.*, *Dixon* v. *United States*, 381 U.S. 68; *Automobile Club of Michigan* v. *Commissioner*, 353 U.S. 180, 184 (see n. 7, *supra*). Thus,

the change in the Commissioner's rulings position was well within his statutory authority. But quite apart from the Commissioner's authority to change his ruling policy, the court of appeals correctly concluded that the modification in the Commissioner's ruling policy governing the exempt status of hospitals is consistent with the broad definition of "charitable" originally considered by Congress and the more expansive definition of the term adopted in the 1959 Regulations.

Although petitioners argue (Br. 17) that the 1959 amendment to the Regulations did not broaden the concept of "charitable," a simple comparison of the narrow specification of "relief of the poor" under the prior Regulations with the current provision that "[t]he term 'charitable' is used * * * in its generally accepted legal sense" refutes their assertion. Indeed, the Regulations' reference to the "generally accepted legal sense" of the term "charitable" is not without significance. As the court of appeals observed (Pet. App. B 48A), the Commissioner, in publishing Rev. Rul. 69-545, properly relied on the laws of charitable trusts where it has been long established that the term "charitable" means far more than benevolence to the poor. See *Green* v. *Connally*, 330 F. Supp. 1150, 1157 (D. D.C.), affirmed *per curiam sub nom. Coit* v. *Green*, 404 U.S. 997.[49]

The evolution of the "charitable" concept in the

[49] See also Zollman, *American Law of Charity* (1924 ed.), pp. 135-136: "Although the relief of the poor, or a benefit to them is, in its popular sense, a necessary ingredient of charity, this is not so in the view of the law."

law of trusts and the Regulation's reference to the meaning of "charitable" in its accepted legal sense demonstrates the correctness of Rev. Rul. 69-545. While certain early charitable trust cases required charitable hospitals to accept all patients regardless of ability to pay,[50] most recent trust cases involving hospitals allow them to qualify for charitable status on the basis of a more varied or broader range of community benefit activities.[51]

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[50] *E.g.*, *Hart* v. *Taylor*, 301 Ill. 344, 133 N.E. 857, 858; *O'Brien* v. *Physicians' Hospital*, 96 Ohio St. 1, 116 N.E. 975, 977.

[51] See, *e.g.*, *City of Richmond* v. *Hospital*, 202 Va. 86, 116 S.E.2d 79; *Methodist Homes, Inc.* v. *Tax Commissioner*, 226 Ore. 298, 360 P.2d 293; *People ex rel. Doctors Hospital* v. *Sexton*, 48 N.Y.S.2d 201, 267 App. Div. 736, affirmed, 295 N.Y. 553, 64 N.E.2d 273; *Evangelical Lutheran Good Samaritan Soc.* v. *County of Gage*, 181 Neb. 831, 151 N.W.2d 446; *Weiss* v. *Swedish Hospital*, 16 Wash.2d 446, 133 P.2d 978; *In re Henderson's Estate*, 17 Cal.2d 853, 112 P.2d 605; *Benton County* v. *Allen*, 170 Ore. 481, 133 P.2d 991; *In re Claim of Assembly Homes* v. *Yellow Medicine Co.*, 273 Minn. 197, 140 N.W.2d 336; *Brattleboro Retreat* v. *Town of Brattleboro*, 106 Vt. 228, 173 Atl. 209; *Southern Methodist Hospital and Sanitorium of Tucson* v. *Wilson*, 51 Ariz. 424, 77 P.2d 458.

The charitable trust cases relied upon by petitioners (Br. 29-30) lend no support to the free hospital care policy they espouse. Only two of the cases decided later than 1922 involve hospitals rather than homes for the aged. The two remaining cases are distinguishable. *Cleveland Osteopathic Hospital* v. *Zangerle*, 153 Ohio 222, 91 N.E.2d 261 (Br. 29), turned on inordinate private profit rather than hospital admissions. In *Jackson County* v. *State Tax Commission*, 521 S.W.2d 378 (Mo.), the court upheld the state tax exemption of a hospital which had no program for furnishing free non-emergency medical care to indigents but maintained an emergency room open to all regardless of ability to pay—just as Hospital *A* in Rev. Rul. 69-545.

This expansion in the concept of "charitable" reflects the fact that the law of charitable trusts has always included a category for purposes beneficial to the community (see, *e.g.*, *Evans* v. *Newton*, 382 U.S. 296, 307-308 (White, J., concurring)), which has traditionally expanded in order to meet the needs of a changing society. *Todd* v. *Citizens' Gas Co. of Indianapolis*, 46 F.2d 855, 865 (C.A. 7), certiorari denied, 283 U.S. 852; *Bozeman Deaconess Foundation* v. *Gallatin Co.*, 151 Mont. 143, 439 P.2d 915; Bogert, *Trusts* (2d ed. 1964), Section 369. Thus, the court of appeals correctly noted (Pet. App. B 48A and nn. 16, 17) that the law of charitable trusts recognizes that in certain circumstances the promotion of health is a charitable purpose, separate and apart from any requirement of free service to the poor. IV Scott on *Trusts* (3d ed. 1967), Section 372; ALI, Restatement of *Trusts* (2d), Secs. 368, 372.[52]

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[52] Petitioners acknowledge (Br. 30) that Professor Scott's view of charity is much broader than the view they advance. They seek, however, to minimize the force of his authority by noting that his treatise had adopted the broader view of charity as early as 1939, but that Treasury did not allow his view in the case of hospitals until 1969. But even assuming, *arguendo*, that the Treasury's original position with respect to tax-exempt hospitals was contrary to that of Professor Scott, that would hardly foreclose the modifications adopted in 1969. See, *e.g.*, *Morrissey* v. *Commissioner*, *supra*, 296 U.S. at 356-357; *Helvering* v. *Wilshire Oil Co.*, *supra*, 308 U.S. at 100-102; *Helvering* v. *Reynolds*, *supra*, 313 U.S. at 431; *Commissioner* v. *P. G. Lake, Inc.*, 356 U.S. 260, 265-266, n. 5.

Given the Regulations' reliance upon the generally accepted legal sense of the term "charity," petitioners' reliance (Br. 18-20) upon the Commissioner's requirement that tax-exempt

The evolution of tax law has proceeded along similar lines. While service to the poor was given more emphasis in the Treasury's initial administration of the charitable standard,[53] several early decisions upheld tax-exempt status on a broader concept of the term "charitable." See, *e.g.*, *Girard Trust Co.* v. *Commissioner*, 122 F.2d 108 (C.A. 3) (temperance society); *Pennsylvania Co. for Insurance on Lives, Etc.* v. *Helvering*, 66 F.2d 284 (C.A. D.C.) (antivivisection society). However, the 1959 promulgation of Section 1.501(c)(3)-1(d)(2) of the Regulations, with its reference to the general legal meaning of the term "charitable," was a formal recognition by the Treasury that free care for indigents would no longer be given exclusive emphasis.[54]

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public interest law firms or consulting services are not permitted to charge for their services is not relevant. Unlike the promotion of health care, which is recognized as an accepted charitable activity, the furnishing of legal or consulting services is not so recognized.

[53] For example, see I.T. 1800, II-2 Cum. Bull. 152 (1923); cf. Sol. Mem. 2160, III-2 Cum. Bull. 151 (1924). But cf. Sol. Op. 159, III-1 Cum. Bull. 480 (1924), which held that a bequest for the construction of a community auditorium was "charitable," thereby recognizing that the term "charitable" included more than relief of the poor.

[54] Petitioners also argue (Br. 48-49) that Rev. Rul. 69-545 should be invalidated because it was issued by the Treasury "with blinders on and totally excluded all reference to the continued needs of poor people * * *." But, as the court of appeals observed (Pet. App. B 56A), the ruling on its face indicates that the interests of the poor were considered by establishing

As the court of appeals correctly recognized (Pet. App. B 52A), the Commissioner did not abolish in Rev. Rul. 69-545 the general requirement that a hospital furnish some type of free care to the indigent. Rather, he simply provided an additional means (free emergency room treatment) by which a hospital could qualify for tax-exempt status within the "generally accepted legal sense" of the statutory term "charitable," which, as we have pointed out, encompasses much more than relief of the indigent. See Treasury Regulations on Income Tax, Section 1.501(c)(3)-1(d)(2). In no sense, therefore, can a general hospital under the current ruling policy systematically exclude those who cannot pay from all treatment and retain its tax-exempt status.

There is accordingly no basis to petitioners' argument that Rev. Rul. 69-545 is contrary to the legislative or administrative history of the "charitable" standard of Section 501(c)(3) of the Code. As we have pointed out, the intent of Congress was to encompass a broad range of humanitarian activities

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the requirement of emergency treatment for all regardless of ability to pay.

There is similarly no merit to petitioners' contention (Br. 53-55) that the Treasury's consideration of the needs of the poor should have been documented on the public record, rather than explained during this litigation. Revenue Rulings are legal opinions issued by the Treasury, not findings of facts or formal investigatory reports. Thus, *Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402, involving several statutes which specifically required that agency officials either make formal findings, or produce evidence, that certain factual conditions existed, is not apposite to this case.

under the rubric "charitable" and to leave the detailed administration of the statute to the Secretary.[55] Thus, the broadening of the "charitable" standard in the 1959 Regulations to include within its compass activities which are "charitable" in the "generally accepted legal sense" of that term is consistent with the congressional design.

Moreover, the 1959 Regulations presaged the eventual modification of the Commissioner's original rulings policy toward hospitals set forth in Rev. Rul. 56-185, which was tied to the "relief of the poor" standard of the old Regulations. Indeed, given the expansive scope of the current regulatory definition of "charitable," it is doubtful that the Treasury could successfully enforce the policy advocated by petitioners

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[55] For this reason, in the past decade the Internal Revenue Service has recognized the charitable status of numerous non-hospital groups which are not involved in the relief of poverty, such as environmental protection organizations (Rev. Rul. 72-560, 1972-2 Cum. Bull. 248), and women's rights organizations (Rev. Rul. 72-228, 1972-1 Cum. Bull. 148).

Additional examples of charitable organizations which are not specifically devoted to the relief of poverty, some of which even charge fees, include day care centers (Rev. Rul. 68-166, 1968-1 Cum. Bull. 255); organizations devoted to encouraging public interest in the dramatic arts (Rev. Rul. 64-175, 1964-1 (Part 1) Cum. Bull. 185); and a nonprofit organization formed and operated to conduct annual public fairs and exhibitions of livestock, poultry and farm products (Rev. Rul. 67-216, 1967-2 Cum. Bull. 180). The classification of varied activities as "charitable" refutes petitioners' contention (Br. 16) that a tax-exempt organization must lessen the burdens of government.

of requiring tax-exempt hospitals to furnish a broad range of free medical care to indigents.[56]

Contrary to petitioners' argument (Br. 20-24), the courts of appeals have not imposed the furnishing of free care to indigents as a requirement for the tax-exempt status of hospitals. Apart from the fact that many of the cases upon which petitioners rely were decided under the now-supplanted "relief of the poor" standard of the 1939 Regulations, there is no case, under either the old or new Regulations which hold that a hospital was not tax exempt solely because it did not provide free care to the indigent.

In deciding those cases, the courts have considered a number of factors, including but not limited to,

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[56] Petitioners argue (Br. 25-28) that the failure of Congress in 1969 to enact a bill passed by the House which would have generally exempted hospitals regardless of the amount of free care they furnished to the indigent demonstrates that Congress disapproved of the policy announced in Rev. Rul. 69-545. But this Court has often admonished that the advocacy of legislation and the failure of Congress to act is a hazardous basis for statutory interpretation. See, *e.g.*, *American Trucking Co.* v. *A., T. & S.F.R. Co.*, 387 U.S. 397, 417-418; *Red Lion Broadcasting Co.* v. *Federal Communications Commission*, 395 U.S. 367, 381-382, n. 11; *Fogarty* v. *United States*, 340 U.S. 8, 13-14; *United States* v. *United Mine Workers*, 330 U.S. 258, 281-282; *Order of Ry. Conductors* v. *Swan*, 329 U.S. 520, 529. The example of Hospital *B* in Rev. Rul. 69-545 may indicate why such legislation may have been considered ill-advised. At all events, the failure of Congress to exempt hospitals generally can hardly constitute rejection of Rev. Rul. 69-545, which more strictly premises exemption upon an emergency room open to all persons, care of Medicare and Medicaid patients, a publicly controlled governing body, and the absence of private benefit (see Pet. App. B 51A-52A and n. 24).

the amount of free care provided by a hospital. Thus, for example, in *Commissioner* v. *Battle Creek, Inc.*, 126 F.2d 405 (C.A. 5), which petitioners cite (Br. 21) as holding that free care is the "basic test for defining a 'charitable' hospital," the decision turned equally on the fact that the hospital was not chartered in terms that ensured that its assets would be dedicated to charitable purposes in the event of its dissolution. Similarly, while the Sixth Circuit in *Harding Hospitals, Inc.* v. *United States*, 505 F.2d 1068, referred to the hospital's negligible indigent care program as one factor evidencing that it was operated so that its earnings inured to the benefit of its private owners, it specifically refused to adopt petitioner's absolute free care standard. As the court there stated: "We do not single out any one or combination of these factors as the consideration crucial to our holding. We conclude only that all these factors, as they occurred in the aggregate in this case, require denying the appellant Hospital the tax exemption for the years in question" (505 F.2d at 1077). Accord: *Sonora Community Hospital* v. *Commissioner*, 46 T.C. 519, 526, affirmed *per curiam*, 397 F.2d 814 (C.A. 9); *Lorain Avenue Clinic* v. *Commissioner*, 31 T.C. 141, 160.

2. There are sound reasons underlying the Commissioner's modification of his rulings policy toward hospitals. As the court of appeals observed, whatever the merits of the prior ruling which required that a tax-exempt hospital furnish free care to indigents to the extent of its financial ability, "there

is no authority for the conclusion that the determination of 'charitable' status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary society" (Pet. App. B 49A).

Unlike the situation early in our nation's history when the hospital as an institution was an almshouse for the poor supported by private philanthropy, the hospital today is the primary community health facility for rich and poor alike. Since 1956, when the Commissioner issued his first revenue ruling concerning the tax-exempt status of hospitals, there have been two dramatic changes in the finances of health care delivery.

First, hospital costs have risen to what this Court has described as "astronomical" proportions, placing private hospitals in "precarious financial straits" *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250, 264-265. Second, the development of both private and public health insurance (*i.e.*, Medicare and Medicaid) has largely displaced self-paying patients and private philanthropy as the principal source of hospital revenue. "The pressure to provide free care has lessened to the extent that these multi-billion dollar programs and private hospital insurance are now paying for many of those whose bills previously went unpaid," *Medicare and Medicaid: Problems, Issues and Alternatives*, Report of the Staff to the Senate Committee on Finance, 91st Cong., 1st Sess. 56 (1970)) (A. 42).

Many of the insurance plans, notably Medicare, Medicaid and Blue Cross, provide reimbursement only on the basis of cost, and thereby generate no surplus for either free care or improvement of facilities. However, at the same time that the amount of excess funds is decreasing, rapid technological change and inflation have demanded an ever accelerating investment by private hospitals for renovation and modernization of facilities.

The institution of Medicare and Medicaid since the promulgation of the first Revenue Ruling has resulted in the admission and treatment by private hospitals of large numbers of insured persons of whom a substantial percentage, in the absence of such governmental reimbursement, would be unable to pay the cost. Thus, a private hospital which meets the criteria of the current Rev. Rul. 69-545, and admits any patient with some form of health insurance, is accepting many of those persons who would have required free or below-cost care in 1956, prior to the advent of Medicare and Medicaid. As a result, the free care for indigents required by the prior Revenue Ruling is of lesser significance for the health care of the poor today than it was in 1956.[57]

[57] Petitioners argue (Br. 38-39) that the policy of Rev. Rul. 69-545 is contrary to the regulations adopted by the Department of Health, Education and Welfare with respect to the grants under the Hill-Burton Act for hospital construction. Under those regulations, the Department specifically defines the amount of free care to the indigent a recipient hospital must provide. However, the Hill-Burton Act is simply one program under which the government purchases health care for the poor in advance of the performance of the services. Indeed, the recipient hospitals' obligation to provide a reasonable amount of free care has been held to be a contractual obligation arising out of the receipt of federal funds. See *Euresti* v. *Stenner*, 458 F.2d 1115 (C.A. 10). Given the relatively small proportion of Hill-Burton funds compared to Medicare and Medicaid payments (see Br. Amicus American Hospital Association 67, n. 111), a federal policy of free health care to indigents cannot be demonstrated from the Hill-Burton program.

Moreover, the emergency room requirements of the current Rev. Rul. 69-545 fulfill a significant part of the hospital care needs of the poor. For it is true, if unfortunate, that the emergency room is to most poor persons what the family doctor is to the economically advantaged. "When health needs become critical, families that do not have adequate financial resources may find the emergency rooms and outpatient clinics of general hospitals the only available resource," *National Advisory Commission on Health Facilities: A Report to the President*, p. 20 (1969) (see Pet. App. B 52A, n. 25).

Finally, the indigent care requirement of Rev. Rul. 56-185, which petitioners seek to have restored to universal application, proved to be administratively unworkable in practice. The standard of that ruling for ascertaining a hospital's ability to provide health care to the poor—"to the extent of its financial ability"—is virtually impossible to apply fairly. Even if a hospital has surplus funds available, does it have "financial ability" to furnish free services if many of its facilities need replacement, if it needs new

technological equipment to enable it to implement modern medical procedures, or if it should initiate new training programs?

Modernization of facilities, installation of new equipment, expansion of training programs all are bona fide charitable purposes because they promote health and benefit the public generally. What is the "financial ability" of a hospital to furnish free care when it has net revenue, but when it also has other critical needs competing for such excess dollars as it may have available? Under the financial ability test of Rev. Rul. 56-185, the Internal Revenue Service presumably would have to determine how much a hospital should spend for free care and how much for other critical needs, a task for which it is singularly ill-equipped.[58] However, the standards implicit in Rev. Rul. 69-545 are less likely to involve the

[58] The unworkability of the old Rev. Rul. 56-185 is amply demonstrated by the Brief Amicus Curiae of the American Public Health Association. It argues (p. 33, n. 68) that a hospital's financial ability to provide free care to indigents can only be measured by excluding the amount represented by its uncollected receivables. But surely a hospital's failure to collect its fees injures its financial capacity and reduces its ability to furnish free care to indigent patients.

Moreover, the Association further argues (Br. 39-40) that much of the current hospital construction is not in the public interest and such funds should be allocated for health care for the poor. But this contention must be contrasted with its earlier criticism (Br. 27) of local governments in California for closing county hospitals and thereby increasing the burdens on the private hospitals. Obviously, the complex nature of the current health care crisis demonstrates that it cannot be solved, or even materially eased, by any single federal tax policy such as the prior Rev. Rul. 56-185.

Treasury in formulating guidelines with respect to the details of hospital administration (see Pet. App. B 53A, n. 26).

Of course, no Treasury-mandated charity requirement can by itself solve the nation's severe health care crisis. Revenue Ruling 56-185 did not, and Rev. Rul. 69-545 cannot be expected to bring quality health care to all who need it. But that is not the issue. As the court of appeals correctly concluded with respect to the question presented here, "Revenue Ruling 69-545 is founded on a permissible definition of the term 'charitable' and is not contrary to any express Congressional intent" (Pet. App. B 53A).

III. THE SECRETARY'S PROMULGATION OF THE REVENUE RULING WAS EXEMPT FROM THE NOTICE AND HEARING REQUIREMENTS OF THE ADMINISTRATIVE PROCEDURE ACT BECAUSE THE RULING WAS AN INTERPRETATIVE RULE

Petitioners alternatively argue (Br. 41-47) that even if Rev. Rul. 69-545 correctly interprets the term "charitable" in Section 501(c)(3) of the Code, the Ruling is nevertheless invalid because the Secretary of the Treasury did not promulgate it in accordance with the notice and hearing requirements of the Administrative Procedure Act, 5 U.S.C. 553. Section 553(b) and (c) of the Administrative Procedure Act provides that a "[g]eneral notice of proposed [agency] rule making shall be published in the Federal Register" and that the agency "shall give interested persons an opportunity to participate in the rule making through submission of written data,

views, or arguments * * *." However, Section 553 (b)(3)(A) specifically excepts from the notice and hearing requirements "interpretative rules, general statements of policy, or rules of agency organizations, procedure or practice."

The court of appeals correctly held (Pet. App. B 53A-56A) that Rev. Rul. 69-545 was not subject to the notice and hearing requirements of the Administrative Procedure Act because it came within the Section 553(b)(3)(A) exception for "interpretative rules." As that court observed, it is well settled that agency rulings that do not bind the affected parties or the courts are interpretative rules within the meaning of Section 553(b)(3)(A). See, *e.g.*, *American President Lines, Ltd.* v. *Federal Maritime Commission*, 316 F.2d 419, 422 (C.A. D.C.); *United States* v. *353 Cases, Etc.*, 247 F.2d 473, 480 (C.A. 8); *Gibson Wine Co.* v. *Snyder*, 194 F.2d 329, 331-332 (C.A. D.C.); *Stearns Elec. Paste Co.* v. *Environmental Protection Agency*, 461 F.2d 293, 304 (C.A. 7). Thus, for example, *Gibson Wine Co.* v. *Snyder*, *supra*, held in analogous circumstances that a letter ruling issued by a Deputy Commissioner of Internal Revenue was an interpretative rule not subject to the notice and hearing requirements of the Administrative Procedure Act. In explaining the "interpretative rule" exception, the court stated (194 F.2d at 331-332):

> The distinctive characteristics of interpretative rulings, as contrasted with so-called regulations, have long been recognized. Administrative officials frequently announce their views as to the meaning of statutes or regulations. Generally speaking, it seems to be established that "regulations," "substantive rules" or "legislative rules" are those which create law, usually implementary to an existing law, whereas interpretative rules are statements as to what the administrative officer thinks the statute or regulation means. * * * "A substantive rule is one which, as I have said, is intended to implement the statutory structure or the statutory powers of an agency. An interpretative rule is one which does not have the full force and effect of a substantive rule but which is in the form of an explanation of particular terms in an Act. If you had an expression in a statute such as 'Interurban Railway,' the query might come up as to what is an 'interurban railway.' A particular agency may adopt a rule defining an interurban railway. That, in a sense, may be called an interpretative rule." * * *

Unlike the cases relied upon by petitioners, which involve substantive agency orders with binding legal effect,[59] the published Revenue Ruling at issue here

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[59] See, *e.g.*, *National Labor Relations Board* v. *Wyman-Gordon Co.*, 394 U.S. 759; *Lewis-Mota* v. *Secretary of Labor*, 469 F.2d 478 (C.A. 2); *Texaco, Inc.* v. *Federal Power Commission*, 412 F.2d 740 (C.A. 3). While several of the other cases cited by petitioners note other factors such as complexity, degree of change and confusion stemming from the agency pronouncement to determine whether it is interpretative, the court of appeals correctly noted (Pet. App. B 55A, n. 30) that such "factors have been considered by the courts * * * [but] are not determinative here where a ruling is clearly interpretative in nature and has no legally binding effect."

is only an interpretation by the Treasury of the statutory term "charitable." Such a ruling is informational in character and represents an announcement of position in much the same way as a speech by a Treasury official or an argument presented to a court. It can hardly be contended that such statements are "rule-making" subject to the notice and hearing requirements of the Administrative Procedure Act. Cf. *Helco Products Co.* v. *McNutt*, 137 F.2d 681, 683-684 (C.A. D.C.). As the Court stated in *Dixon* v. *United States*, *supra*, 381 U.S. at 73, "[revenue rulings] are merely guidelines for * * * [Internal Revenue Service] personnel." Thus, this Court and the lower federal courts have consistently held that Revenue Rulings are legal opinions issued by the Commissioner's staff which have no binding force or effect of law and are subject to change or even retroactive revocation. See, *e.g.*, *Helvering* v. *N.Y. Trust Co.*, 292 U.S. 455, 468; *Biddle* v. *Commissioner*, 302 U.S. 573, 582; *Bartels* v. *Birmingham*, 332 U.S. 126, 131-132; *Automobile Club of Michigan* v. *Commissioner*, 353 U.S. 180, 184; *Sims* v. *United States*, 252 F.2d 434, 438 (C.A. 4); *United States* v. *Bennett*, 186 F.2d 407, 410 (C.A. 5); Rev. Rul. 2, 1953-1 Cum. Bull. 484. See also *Skidmore* v. *Swift & Co.*, 323 U.S. 134, 137-138, 140. Indeed, the limited effect of Revenue Rulings [60] is described in each

[60] Unlike Revenue Rulings which are not binding on the courts and are therefore not subject to the notice and hearing requirements of the Administrative Procedure Act, Treasury Regulations are issued pursuant to notice and hearing under

volume of the Cumulative Bulletin in which they are published, as follows (1969-2 Cum. Bull. xxii):

> Revenue Rulings represent the conclusions of the Service on the application of the law to the entire state of facts involved. * * *
>
> Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court

that Act. There are two types of Regulations promulgated by the Treasury under its tax administration authority, legislative regulations and interpretative regulations. The former (see n. 15, *supra*) are issued subject to a broad statutory delegation and are considered to have the force and effect of law and are essentially binding on the courts and the affected parties. See, *e.g.*, *A.T. & T. Co.* v. *United States*, 299 U.S. 232, 236-237; *Lucas* v. *American Code Co.*, 280 U.S. 445, 449. See also Alvord, *Treasury Regulations and the Wilshire Oil Case*, 40 Col. L. Rev. 252, 259-260 (1940); Feller, *Addendum to the Regulations Problem*, 54 Harv. L. Rev. 1311, 1320-1321 (1941); Surrey, *The Scope and Effect of Treasury Regulations under the Income, Estate, and Gift Taxes*, 88 U. Pa. L. Rev. 556, 557-558 (1940).

The Administrative Procedure Act does not appear to be applicable to interpretative regulations, which, like Revenue Rulings, set forth the Treasury's construction of various sections of the Internal Revenue Code. However, because it is often difficult to distinguish between legislative and interpretative regulations, the Treasury issues both types of regulations subject to the notice and hearing requirements of the Act. See Rogovin, *The Four R's: Regulations, Rulings, Reliance, and Retroactivity*, *supra*, 43 Taxes at 759, n. 6.

> decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

Petitioners argue (Br. 47) that the Section 553 (b)(3)(A) exception for interpretative rules is inapplicable here because the "affected parties, people unable to pay for hospital care, are effectively bound by Revenue Ruling 69-545." But the "affected parties" for purposes of the Administrative Procedure Act are not prospective hospital patients but the hospitals themselves, since it is their tax liability and eligibility for deductible contributions that is the subject of Rev. Rul. 69-545.

If a hospital chose not to maintain an emergency room open to all persons regardless of their ability to pay and litigated the question of its entitlement to tax-exempt status, the conclusion of Rev. Rul. 69-545 that such a hospital was not exempt would not be legally binding on either the hospital or the courts. To the contrary, if the court disagreed with the Treasury's open emergency room requirement, it would be free to reject it, despite its promulgation in a Revenue Ruling.[61] Accordingly, the ruling fits the classic definition of an "interpretative rule" which

[61] Indeed, petitioners do not challenge the court of appeals' statement (Pet. App. B 55A) that they "concede that Revenue Ruling 69-545 has no independent binding effect and that the courts are not bound by it unless they choose to accept it as a proper interpretation of the meaning of the word 'charitable' as used in § 501(c)(3)."

is not subject to the notice and hearing requirements of the Administrative Procedure Act.[62]

CONCLUSION

For the reasons stated, the judgment of the court of appeals should be reversed and the case remanded to the district court with instructions to dismiss the complaint for lack of jurisdiction.[63] Alternatively,

[62] Of course, even if Rev. Rul. 69-545 were subject to the notice and hearing requirements of the Administrative Procedure Act, that conclusion would not justify the restoration of the prior Rev. Rul. 56-185 sought by petitioners. Such a result could only be achieved if the current Rev. Rul. 69-545 were held to be substantively incorrect and the prior Ruling were held to embody the sole correct interpretation of the statutory term "charitable." Thus, the invalidation of the current Rev. Rul. 69-545 for failure to comply with the notice and hearing requirements would not prevent the Treasury from continuing to employ the criteria set forth in that Ruling.

[63] It is well settled that if a complaint is dismissed on the merits in the courts below, but should have been dismissed on jurisdictional grounds, this Court will vacate the judgment and order entry of a judgment dismissing the complaint for lack of jurisdiction. *E.g.*, *Shawnee Sewerage & Dr. Co.* v. *Stearns*, 220 U.S. 462, 471-472; *Smallwood* v. *Gallardo*, 275 U.S. 56; *Piedmont & Nor. Ry.* v. *United States*, 280 U.S. 469, 478; *Gully* v. *Interstate Nat. Gas Co.*, 292 U.S. 16. This is the case even if the appeal to this Court is taken by the party which had generally prevailed in the court of appeals. See *Electrical Corp.* v. *Thomas Co.*, 307 U.S. 241.

the judgment of the court of appeals should be affirmed.

Respectfully submitted.

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Solicitor General.

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SEPTEMBER 1975.

APPENDIX A

Internal Revenue Code of 1954 (26 U.S.C.):

SEC. 170. CHARITABLE, ETC., CONTRIBUTIONS AND GIFTS.

* * * * *

(c) *Charitable Contribution Defined.* — *For* purposes of this section, the term "charitable contribution" means a contribution or gift to or for the use of—

* * * * *

(2) A corporation, trust, or community chest, fund, or foundation—

* * * * *

(B) organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes or for the prevention of cruelty to children or animals;

* * * * *

SEC. 501. EXEMPTION FROM TAX ON CORPORATIONS, CERTAIN TRUSTS, ETC.

* * * * *

(c) *List of Exempt Organizations.*—The following organizations are referred to in subsection (a):

* * * * *

(3) Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to

the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office.

* * * * *

SEC. 7421. PROHIBITION OF SUITS TO RESTRAIN ASSESSMENT OR COLLECTION.

(a) *Tax.*—Except as provided in sections 6212(a) and (c), 6213(a), and 7426(a) and (b)(1), no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed.

* * * * *

SEC. 7801. AUTHORITY OF DEPARTMENT OF THE TREASURY.

(a) *Powers and Duties of Secretary.*—Except as otherwise expressly provided by law, the administration and enforcement of this title shall be performed by or under the supervision of the Secretary of the Treasury.

* * * * *

SEC. 7802. COMMISSIONER OF INTERNAL REVENUE.

There shall be in the Department of the Treasury a Commissioner of Internal Revenue, who shall be appointed by the President, by and with

the advice and consent of the Senate. The Commissioner of Internal Revenue shall have such duties and powers as may be prescribed by the Secretary.

5 U.S.C. 553:

Rule making.

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—

* * * * *

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

* * * * *

28 U.S.C. 2201:

Creation of remedy.

In a case of actual controversy within its jurisdiction, except with respect to Federal taxes,

any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought. Any such declaration shall have the force and effect of a final judgment or decree and shall be reviewable as such.

28 U.S.C. 2202:

Further relief.

Further necessary or proper relief based on a declaratory judgment or decree may be granted, after reasonable notice and hearing, against any adverse party whose rights have been determined by such judgment.

Treasury Regulations on Income Tax (1954 Code) (26 C.F.R.):

§ 1.501(c)(3)-1 *Organizations organized and operated for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals.*

* * * * *

(d) *Exempt purposes.* * * *

(2) *Charitable defined.* The term "charitable" is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501 (c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions. Such term includes: Relief of the

poor and distressed or of the underprivileged; advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human and civil rights secured by law; or (iv) to combat community deterioration and juvenile delinquency. The fact that an organization which is organized and operated for the relief of indigent persons may receive voluntary contributions from the persons intended to be relieved will not necessarily prevent such organization from being exempt as an organization organized and operated exclusively for charitable purposes. The fact that an organization, in carrying out its primary purpose, advocates social or civic changes or presents opinion on controversial issues with the intention of molding public opinion or creating public sentiment to an acceptance of its views does not preclude such organization from qualifying under section 501(c)(3) so long as it is not an "action" organization of any one of the types described in paragraph (c)(3) of this section.

* * * * *

APPENDIX B

Rev. Rul. 69-545, 1969-2 Cum. Bull. 117

Advice has been requested whether the two non-profit hospitals described below qualify for exemption from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954. The articles of organization of both hospitals meet the organizational requirements of section 1.501(c)(3)-1(b) of the Income Tax Regulations, including the limitation of the organizations' purposes to those described in section 501(c)(3) of the Code and the dedication of their assets to such purposes.

Situation 1. Hospital *A* is a 250-bed community hospital. Its board of trustees is composed of prominent citizens in the community. Medical staff privileges in the hospital are available to all qualified physicians in the area, consistent with the size and nature of its facilities. The hospital has 150 doctors on its active staff and 200 doctors on its courtesy staff. It also owns a medical office building on its premises with space for 60 doctors. Any member of its active medical staff has the privilege of leasing available office space. Rents are set at rates comparable to those of other commercial buildings in the area.

The hospital operates a full time emergency room and no one requiring emergency care is denied treatment. The hospital otherwise ordinarily limits admissions to those who can pay the cost of their hospitalization, either themselves, or through private

health insurance, or with the aid of public programs such as Medicare. Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients.

The hospital usually ends each year with an excess of operating receipts over operating disbursements from its hospital operations. Excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research.

Situation 2. Hospital *B* is a 60-bed general hospital which was originally owned by five doctors. The owners formed a non-profit organization and sold their interests in the hospital to the organization at fair market value. The board of trustees of the organization consists of the five doctors, their accountant, and their lawyer. The five doctors also comprise the hospital's medical committee and thereby control the selection and the admission of other doctors to the medical staff. During its first five years of operation, only four other doctors have been granted staff privileges at the hospital. The applications of a number of qualified doctors in the community have been rejected.

Hospital admission is restricted to patients of doctors holding staff privileges. Patients of the five original physicians have accounted for a large majority of all hospital admissions over the years. The hospital maintains an emergency room, but on a

relatively inactive basis, and primarily for the convenience of the patients of the staff doctors. The local ambulance services have been instructed by the hospital to take emergency cases to other hospitals in the area. The hospital follows the policy of ordinarily limiting admissions to those who can pay the cost of services rendered. The five doctors comprising the original medical staff have continued to maintain their offices in the hospital since its sale to the nonprofit organization. The rental paid is less than that of comparable office space in the vicinity. No office space is available for any of the other staff members.

Section 501(c)(3) of the Code provides for exemption from Federal income tax of organizations organized and operated exclusively for charitable, scientific, or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual.

Section 1.501(c)(3)-1(d)(1)(ii) of the regulations provides that an organization is not organized or operated exclusively for any purpose set forth in section 501(c)(3) of the Code unless it serves a public rather than a private interest.

Section 1.501(c)(3)-1(d)(2) of the regulations states that the term "charitable" is used in section 501(c)(3) of the Code in its generally accepted legal sense.

To qualify for exemption from Federal income tax under section 501(c)(3) of the Code, a nonprofit hospital must be organized and operated exclusively

in furtherance of some purpose considered "charitable" in the generally accepted legal sense of that term, and the hospital may not be operated, directly or indirectly, for the benefit of private interests.

In the general law of charity, the promotion of health is considered to be a charitable purpose. *Restatement (Second), Trusts*, sec. 368 and sec. 372; IV *Scott on Trusts* (3rd ed. 1967), sec. 368 and sec. 372. A nonprofit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose. If it meets the other requirements of section 501(c)(3) of the Code, it will qualify for exemption from Federal income tax under section 501(a).

Since the purpose and activity of Hospital *A*, apart from its related educational and research activities and purposes, are providing hospital care on a nonprofit basis for members of its community, it is organized and operated in furtherance of a purpose considered "charitable" in the generally accepted legal sense of that term. The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes of the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the com-

munity. *Restatement (Second), Trusts*, sec. 368, comment (b) and sec. 372, comments (b) and (c); IV *Scott on Trusts* (3rd ed. 1967), sec. 368 and sec. 372.2. By operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, Hospital *A* is promoting the health of a class of persons that is broad enough to benefit the community.

The fact that Hospital *A* operates at an annual surplus of receipts over disbursements does not preclude its exemption. By using its surplus funds to improve the quality of patient care, expand its facilities, and advance its medical training, education, and research programs, the hospital is operating in furtherance of its exempt purposes.

Furthermore, Hospital *A* is operated to serve a public rather than a private interest. Control of the hospital rests with its board of trustees, which is composed of independent civil leaders. The hospital maintains an open medical staff, with privileges available to all qualified physicians. Members of its active medical staff have the privilege of leasing available space in its medical building. (See Rev. Rul. 69-464, page 132, this Bulletin.) It operates an active and generally accessible emergency room. These factors indicate that the use and control of Hospital *A* are for the benefit of the public and that no part of the income of the organization

is inuring to the benefit of any private individual nor is any private interest being served.

Accordingly, it is held that Hospital *A* is exempt from Federal income tax under section 501(c)(3) of the Code.

Hospital *B* is also providing hospital care. However, in order to qualify under section 501(c)(3) of the Code, an organization must be organized and operated *exclusively* for one or more of the purposes set forth in that section. Hospital *B* was initially established as a proprietary institution operated for the benefit of its owners. Although its ownership has been transferred to a nonprofit organization, the hospital has continued to operate for the private benefit of its original owners who exercise control over the hospital through the board of trustees and the medical committee. They have used their control to restrict the number of doctors admitted to the medical staff, to enter into favorable rental agreements with the hospital, and to limit emergency room care and hospital admission substantially to their own patients. These facts indicate that the hospital is operated for the private benefit of its original owners, rather than for the exclusive benefit of the public. See *Sonora Community Hospital* v. *Commissioner*, 46 T.C. 519 (1966), aff'd 397 F.2d 814 (1968).

Accordingly, it is held that Hospital *B* does not qualify for exemption from Federal income tax under section 501(c)(3) of the Code. In considering whether a nonprofit hospital claiming such exemption

is operated to serve a private benefit, the Service will weigh all of the relevant facts and circumstances in each case. The absence of particular factors set forth above or the presence of other factors will not necessarily be determinative.

Even though an organization considers itself within the scope of *Situation* 1 of this Revenue Ruling, it must file an application on Form 1023, Exemption Application, in order to be recognized by the Service as exempt under section 501(c)(3) of the Code. The application should be filed with the District Director of Internal Revenue for the district in which is located the principal place of business or principal office of the organization. See section 1.501(a)-1 of the regulations.

Revenue Ruling 56-185, C.B. 1956-1, 202 sets forth requirements for exemption of hospitals under section 501(c)(3) more restrictive than those contained in this Revenue Ruling with respect to caring for patients without charge or at rates below cost. In addition, the fourth requirement of Revenue Ruling 56-185 is ambiguous in that it can be read as implying that the possibility of "shareholders" or "members" sharing in the assets of a hospital upon its dissolution will not preclude exemption of the hospital as a charity described in section 501(c)(3) of the Code. Section 1.501(c)(3)-1(b)(4) of the regulations promulgated subsequent to Revenue Ruling 56-185 makes it clear, however, that an absolute dedication of assets to charity is a precondition to exemption under section 501(c)(3) of the Code.

Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost. Furthermore, requirement four has been modified by section 1.501(c)(3)-1(b)(4) of the regulations.

Rev. Rul. 56-185, 1956-1 Cum. Bull. 202

> Criteria or tests to be met in determining whether a hospital qualifies for exemption from Federal income tax under section 501(a) of the Internal Revenue Code of 1954 as an organization described in section 501(c)(3) thereof.

Advice has been requested concerning the criteria or tests to be met in determining whether a hospital can qualify for exemption from income tax as a public charitable organization.

Section 501(c) of the Internal Revenue Code of 1954 describes certain organizations exempt from income tax under section 501(a) and reads, in part, as follows:

> (3) Corporations, and any community chest, fund of foundation, organized and operated exclusively for religious, charitable, scientific * * * purposes, * * * and no part of the net earnings of which inures to the benefit of any private shareholder or individual, and no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office.

The only ground upon which a hospital may be held to be exempt under section 501(c)(3) of the Code is that it is organized and operated primarily for educational, scientific or public charitable purposes. Usually, the ground for exemption is that it is organized and operated for public charitable purposes. The Supreme Court of the United States in *Helvering* v. *Susan D. Bliss et al.*, 293 U.S. 144, Ct. D. 884, C.B. XIII-2, 191 (1934), held that the provisions of law granting exemption of income devoted to charity are liberalizations of the law in the taxpayer's favor, were begotten from motives of public policy, and are not to be narrowly construed. Thus, in regard to hospitals and similar organizations, the Internal Revenue Service takes the position that the term "charitable" in its legal sense and as it is used in section 501(c)(3) of the Code contemplates an implied public trust constituted for some public benefit, the income or beneficial interest of which may not inure to the benefit of any private shareholder or individual.

In order for a hospital to establish that it is exempt as a public charitable organization within the contemplation of section 501(c)(3), it must, among other things, show that it meets the following general requirements:

1. It must be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick. A nonprofit hospital chartered only in general terms as a charitable corporation can meet the test as be-

ing organized exclusively for charitable purposes. See *Commissioner* v. *Battle Creek, Inc.*, 126 Fed. (2d) 405.

2. It must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.

3. It must not restrict the use of its facilities to a particular group of physicians and surgeons, such as a medical partnership or association, to the exclusion of all other qualified doctors. Such limitation on the use of hospital facilities is inconsistent with the public service concept inherent in section 501(c)(3) and the prohibition against the inurement of benefits to private shareholders or individuals. It is recog-

nized, however, that in the operation of a hospital there must of necessity be some discretionary authority in the management to approve the qualifications of those applying for the use of the medical facilities. The size and nature of facilities may also make it necessary to impose limitations on the extent to which they may be made available to all reputable and competent physicians in the area.

4. Its net earnings must not inure directly or indireclty to the benefit of any private shareholder or individual. This includes the use by or benefit to its members of its earnings by way of a distribution of profits, the payment of excessive rents or excessive salaries, or the use of its facilities to serve their private interests. If provision is made in the bylaws for dividends, exemption will not be allowed even though no dividends have been declared. Exemption will not be defeated, however, merely because the shareholders or members might possibly at some future date share in the assets upon dissolution in the absence of a case of mala fides where there appears to be a plan on the part of the shareholder or individual to acquire assets on the dissolution of the corporation.

A community hospital of the type supported partly by contributions from the general public and/or public grants from a city, county or state, normally meets the requirements of section 501(c)(3) as a public charitable organization. It is formed for the purpose of furnishing hospital facilities to all persons in the community at the lowest possible cost and

necessarily accepts patients who are unable to pay for hospital facilities in order to retain the support of the community. A nominal charity record for a given period of time, in the absence of charitable demands of the community, will not affect its right to continued exemption. On the other hand, a hospital formed by one or more physicians in a community who may own the capital stock thereof or rent the hospital facilities to a corporation which they control requires careful study to determine whether it is being operated in part to service their interest, directly or indirectly. See I. T. 2421, C.B. VII-2, 150 (1928).

A hospital formed to operate on a membership basis to provide, at fixed rates, prepaid hospitalization to its members is not a charitable organization within the meaning of section 501(c)(3) of the Code. Compare G.C.M. 22554, C.B. 1941-1, 243. But exemption will not be denied merely because the hospital maintains a prepayment plan, so long as such plan is available to all persons living in the area and so long as the hospital makes available its facilities to the indigent as well as to pay patients to the same extent as any other hospital not operated for profit.

A hospital which is organized as required by section 501(c)(3) of the Code, but which engages primarily in operations foreign to its stated purposes, cannot qualify as a charitable organization under that section. Conversely, a hospital, otherwise exempt, will not lose its exempt status by reason of engaging in operations unrelated to its stated pur-

poses if such operations may be considered as merely incidental. Such a hospital will, however, be required to file an income tax return, Form 990-T, U.S. Exempt Organization Business Income Tax Return, if its gross income (included in computing unrelated business taxable income) for the taxable year is $1,000 or more.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 1378-71

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL., PLAINTIFFS

v.

GEORGE P. SHULTZ, ET AL., DEFENDANTS

DEFENDANTS' PROGRESS REPORT OF ACTION TAKEN TO IMPLEMENT THIS COURT'S ORDER OF JANUARY 29, 1974

Pursuant to the direction in this Court's Order and Judgment filed January 29, 1974, Defendants enclose a proposed Revenue Ruling and a proposed Revenue Procedure which reflect the Internal Revenue Service's progress in the direction of implementing this Court's Order.

DATED: APRIL 1, 1974.

/s/ John J. McCarthy
JOHN J. MCCARTHY, Chief
General Litigation Section
Tax Division
U. S. Department of Justice
Washington, D.C. 20530

/s/ Donald J. Gavin
DONALD J. GAVIN
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Of Counsel:

EARL J. SILBERT
United States Attorney

[Certificate of Service Omitted]

Control No. 74-3-05623

PART I

SECTION 501.—EXEMPTION FROM TAX ON CORPORATIONS, CERTAIN TRUSTS, ETC.

26 CFR 1.501(c)(3)-1: Organizations organized and operated for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals.

Rev. Rul.

The purpose of this revenue ruling is to comply with the order of the United States District Court for the District of Columbia entered January 29, 1974 in *Eastern Kentucky Welfare Rights Organization* v. *Shultz*, —— Fed. Supp. —— (D. D.C. 1974), relating to the position of the Internal Revenue Service respecting the qualification of a nonprofit hospital as a charitable organization for federal income tax purposes under Rev. Rul. 69-545, 1969-2 C.B. 117. The court held that the action of the Service in that revenue ruling in modifying its position with respect to the charitable qualification of nonprofit hospitals previously enunciated in Rev. Rul. 56-185, 1956-2 C.B. 202, was void and without effect, and directed the Service, among other things, to reinstate the requirement of Rev. Rul. 56-185 relating to the treatment of indigent patients.

The opinion and order of the court are presently on appeal by the government to the United States

Court of Appeals for the District of Columbia Circuit, *Eastern Kentucky Welfare Rights Organization* v. *Shultz*, D.C. Cir. #74-1293, and accordingly the requirements stated in this Rev. Rul. and in Rev. Proc. ——, page —— of this Bulletin may be modified as a result of appellate review.

In Rev. Rul. 56-185, 1956-1 C.B. 202 the Service held that to qualify as a charitable organization described in section 501(c)(3) a nonprofit hospital must, among other requirements, be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay.

In Rev. Rul. 69-545, 1969-2 C.B. 117 the Service modified the above requirement of Rev. Rul. 56-185 as an absolute condition of exemption. It held that under certain circumstances a nonprofit hospital may be operating in such a way as to confer a sufficiently broad community benefit in the charitable sense that it will qualify as a charitable organization under section 501(c)(3) of the Code, notwithstanding the fact that it does not care for indigent patients without charge or at rates below cost.

On the basis of its decision in *Eastern Kentucky* regarding the invalidity of the Service's action in Rev. Rul. 69-545, the court entered an order dated January 29, 1974 enjoining the Secretary of the Treasury and the Commissioner of Internal Revenue from:

> Granting tax exempt status under section 501 (c)(3) and allowing deductions for contributions

under section 170(a)-(c) to private nonprofit hospitals unless and until said hospitals:

a. Satisfy the requirements found in Revenue Ruling 56-185, in particular, that they:

> (1) be operated, to the extent of their financial ability, for those not able to pay for services and not exclusively for those who are able and expected to pay; (2) furnish the above "charitable" services on a reduced rate and below cost or no charge basis; (3) not refuse patients in need of hospital care who cannot pay.

b. Conspicuously post, in appropriate accessible public areas, notice, to be prepared by the defendants and subject to Court approval, which shall include:

> (1) That the hospital has applied for or has been granted tax exempt status under § 501(c)(3) of the Code; (2) An intelligible recitation of the previously mentioned provisions of Revenue Ruling 56-185.

The practical effect of the court's opinion and order is to nullify the holding of Rev. Rul. 69-545. In compliance with the court's order, therefore, Rev. Rul. 69-545 is hereby suspended and the requirements of Rev. Rul. 56-185 are reinstated, particularly with respect to the requirement of that ruling that a hospital must:

. . . be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able to and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.

Also, in accordance with the court's order, to qualify for recognition or continued recognition of exemption as an organization described in section 501(c)(3) and as an organization contributions to which are deductible under section 170 of the Code, a nonprofit hospital must post the notice directed by the court and prescribed in Rev. Proc. —, page — of this Bulletin.

Under the authority granted by section 7805(b) of the Code, this revenue ruling will not be applied prior to ————————, the date of its publication in the Internal Revenue Bulletin, with respect to nonprofit hospitals that have been relying upon rulings or determination letters recognizing their exempt status as organizations described in section 501(c)(3) of the Code.

Control No. 74-3-05622

PART V

ADMINISTRATIVE, PROCEDURAL, AND MISCELLANEOUS MATTERS

26 CFR 601.201: Rulings and determination letters. (Also Part I, Section 501; 1.501(a)-1.)

Rev. Proc.

SECTION 1. PURPOSE

This Revenue Procedure discusses the requirements ordered by the court in *Eastern Kentucky Welfare Rights Organization* v. *Shultz*, —— F. Supp. —— (D. D.C. 1974) with respect to the Internal Revenue Service's recognition of exemption of nonprofit hospitals under section 501(c)(3) of the Internal Revenue Code of 1954 and the deductibility under section 170 of contributions to such hospitals. See Rev. Rul. 74- ——, page —, of this Bulletin.

SEC. 2. BACKGROUND

.01 The United States District Court for the District of Columbia in the *Eastern Kentucky* case, *supra* has ordered the Internal Revenue Service to reinstate certain provisions of Rev. Rul. 56-185, 1956-1 C.B. 202 which were modified in Rev. Rul. 69-545, 1969-2 C.B. 117, and has enjoined the Service from recognizing the exempt status under section 501(c)(3) of the Code and from allowing deductions for contributions under section 170 to hospitals that do not post notice in "appropriate accessible public areas" that:

1. The hospital has applied for exemption or has been recognized as exempt under section 501(c)(3) of the Code; and

2. as a tax exempt hospital it must provide care to indigent patients without charge or below cost to the extent required by Rev. Rul. 56-185 as reinstated by 74-———.

.02 The provision of Rev. Rul. 56-185, *supra*, reinstated by Rev. Rul. 74-———, provides as one of the requirements of qualification as a charitable organization described in section 501(c)(3) that a hospital must:

> ". . . be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able to and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses

of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered."

SEC. 3. PROCEDURES FOR RECOGNITION OF EXEMPTION AND DEDUCTIBILITY OF CONTRIBUTIONS FOR HOSPITALS

.01 The above requirement of rendering care to the extent of its financial ability to those not able to pay for the service will apply to hospitals seeking recognition of exemption under section 501(c)(3) of the Code and to hospitals that have been recognized as exempt thereunder.

.02 Hospitals applying for recognition of exempt status under section 501(c)(3) of the Code will be denied such recognition if they do not agree to post the required notice provided by Section 4. In the case of hospitals that have been recognized as exempt under section 501(c)(3), refusal to post the

required notice provided by Section 4 in accordance with the terms of this revenue procedure will result in revocation of recognition of exemption under section 501(c)(3).

.03 The treatment of contributions will be governed by the usual procedures respecting deductibility of charitable contributions, as set out in Rev. Proc. 72-39, 1972-2 C.B. 818, which provides in part as follows:

> Where an organization listed in Publication No. 78 ceases to qualify as an organization contributions to which are deductible under section 170 of the Code and the Service subsequently revokes a ruling or a determination letter previously issued to it, contributions made to the organization by persons unaware of the changes in the status of the organization generally will be considered allowable if made on or before the date of publication of the Internal Revenue Bulletin announcing that contributions are no longer deductible. However, the Service is not precluded from disallowing a deduction for any contribution made after an organization ceases to qualify under section 170, where the contributor (1) had knowledge of the revocation of the ruling or determination letter, (2) was aware that such revocation was imminent, or (3) was in part responsible for, or was aware of, the activities or deficiencies on the part of the organization that gave rise to the loss of qualification.

SEC. 4. THE NOTICE

.01 The notice is a statement of the hospital's commitment to care, to the extent of its financial ability to do so, for patients who cannot afford to pay for medical services, and is intended to inform the public of this commitment. The notice must be printed on heavy white paper or white cardboard at least one foot square. The notice must be printed in black 24 point medium bold type face. The notice must be captioned and read as follows:

NOTICE OF CHARITABLE SERVICES

THIS HOSPITAL HAS BEEN RECOGNIZED AS EXEMPT (OR IS SEEKING RECOGNITION OF EXEMPTION) FROM FEDERAL INCOME TAX AS A CHARITABLE ORGANIZATION. ALTHOUGH IT IS NECESSARY TO CHARGE THOSE ABLE TO PAY FOR SERVICES RENDERED IN ORDER TO MEET OUR OPERATING EXPENSES, TO THE EXTENT OF OUR FINANCIAL ABILITY WE DO NOT DENY MEDICAL TREATMENT TO THOSE UNABLE TO PAY ALL OR PART OF OUR CHARGES FOR SUCH SERVICES

.02 Where appropriate, the Service may advise hospitals that they must post a translation of this notice in a foreign language. Usually, this will occur where a hospital serves a community with a substantial number of non-English speaking residents.

.03 This notice must be permanently posted in the public areas of a hospital's admissions office, emergency room, business or credit office, and lobby so as to be clearly visible to the public.

.04 The notice must be posted within a reasonable period of time after ————————, the date of publication of this revenue procedure in the Internal Revenue Bulletin. Normally, ninety days will be deemed a reasonable period of time.

Assistant Commissioner
(Technical)

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 1378-71

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZITION, ET AL., PLAINTIFFS

vs.

GEORGE P. SHULTZ, ET AL., DEFENDANTS

CERTIFICATE OF SERVICE

Copies of the Plaintiffs' Response to Defendants' Progress Report of Action Taken to Implement This Court's Order of January 28, 1974 have been served by first class mail upon all counsel of record in the above proceeding on April 10, 1974.

/s/ Marilyn G. Rose
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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 1378-71

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL., PLAINTIFFS

vs.

GEORGE P. SHULTZ, ET AL., DEFENDANTS

PLAINTIFFS' RESPONSE TO DEFENDANTS' PROGRESS REPORT OF ACTION TAKEN TO IMPLEMENT THIS COURT'S ORDER OF JANUARY 28, 1974

In the Order of this Court of January 28, 1974, Defendants were ordered to

> "take the necessary and immediate steps to implement this order, including but not limited to revoking the voided portion of Revenue Ruling 69-545 and promulgating in its stead appropriate Rulings, and shall report their progress to the Court within 60 days of the entry of this Order, and at such further time as the Court deems necessary."

On April 1, 1974, Defendants filed a proposed Revenue Ruling and a proposed Revenue Procedure to "reflect the Internal Revenue Service's progress in the direction of this Court's Order." These documents do the following:

(1) The proposed ruling, after reciting the history of the litigation and the Order, suspends Rev.Rul. 69-545 and reinstates the requirements of Rev.Rul. 56-

185, in particular, the section of the latter that a hospital must "be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able to and expected to pay." The proposed ruling also includes the requirement of a posting of a Notice (as set forth in the Order of this Court), and provides that it will not be applied prior to the date it appears in the Internal Revenue Bulletin.

(2) The Revenue Procedure involves the procedures under which hospitals will be recognized as eligible for § 501(c) (3) status and contributions to them will be recognized deductible under § 170(a)-(c). Basically it restates the requirement that hospitals render care to the extent of their financial ability for those not able to pay, and that they post a Notice of the hospital's commitment as a condition of obtaining and maintaining such tax exemption status. The Notice itself is set forth, and states as follows:

NOTICE OF CHARITABLE SERVICES

THIS HOSPITAL HAS BEEN RECOGNIZED AS EXEMPT (OR IS SEEKING RECOGNITION OF EXEMPTION) FROM FEDERAL INCOME TAX AS A CHARITABLE ORGANIZATION. ALTHOUGH IT IS NECESSARY TO CHARGE THOSE ABLE TO PAY FOR SERVICES RENDERED IN ORDER TO MEET OUR OPERATING EXPENSES, TO THE EXTENT OF OUR FINANCIAL ABILITY WE DO NOT DENY MEDICAL TREATMENT TO THOSE UNABLE TO PAY ALL OR PART OF OUR CHARGES FOR SUCH SERVICES.

Plaintiffs believe that these proposed actions are inadequate, and do not meet the Order of this Court.

(1) *The Inadequacy of Enforcement*

Whether or not hospitals were abiding by the requirements set forth in Revenue Ruling 56-185 prior to October of 1969, they have been freed of such obligations since that date. Plaintiffs believe that more has to be done to obtain compliance, that objective standards should be set forth under which compliance would be judged, and that enforcement should be developed, to correct the effects of the policy which this Court voided.

With respect to standards, the cases out of which Revenue Ruling 56-185 developed generally found 1-3% of gross revenues inadequate and 5-8% adequate. More recently, HEW, when faced with setting standards by which hospitals constructed with Federal Hill-Burton moneys, first proposed a standard of 5% of cost of operations or 25% of net profits, whichever was greater (37 Fed.Reg.No.75, April 18, 1972), and later after comments from hospitals and poor people set a "compromise" of 3% of cost of operations or 10% of the Hill-Burton grant, whichever was the lesser (37 Fed.Reg.No.142, July 22, 1972). It would be more meaningful if IRS directed itself to setting objective measures of compliance to guide both poor people and hospitals.

With respect to enforcement, in the first place, the Notice is inadequate to tell a poor person *whether* he is eligible for free and below cost service, *whether*

the hospital is financially able to serve him, and *to whom* he complains if he has been denied free or below cost care. Certainly, at a minimum (aside from developing standards) the person denied free care should know where to lodge a complaint (e.g., the local office of Internal Revenue).

Secondly, IRS operates on a self-policing system, i.e., the taxpayer reports his gross income, his net (i.e., taxable) income, and his liability. Hospitals which have 501(c)(3) status file annual reports (the form 990). IRS has already indicated some change in Form 1023 (which is the application form for 501(c)(3) status) which contains some questions directed to the service of a 501(c)(3) hospital. It would appear to be most appropriate for IRS to develop questions, directed toward ascertaining: the hospital's gross revenues, its cost of operations, its "free service" (specifically excluding its "bad debts"), total number of inpatients and total number of free inpatients. These questions should be added to Form 990 for 1974 reports (due in 1975) and for later years.

(2) *The Total Voiding of 69-545*

Whereas in the enforcement area IRS has done too little in the revocation area it may have done too much. IRS has contended in this Court that participation in governmental programs such as Medicare and Medicaid and the maintenance of an open emergency room are requirements of "charitable" tax status, and that 69-545 so requires. Although there

is some ambiguity in the Ruling is this regard, IRS has not spelled out these requirements elsewhere. Further, Plaintiffs do not challenge such requirements, nor do we read the Court's decision and order as voiding them. Indeed, the language of the Order, quoted above, directs IRS "to revoking the voided portion of Revenue Ruling 69-545." We believe that the more acceptable approach would have been to have limited revocation as directed by the Court or to have incorporated the unchallenged portions of 69-545 in the new Revenue Ruling.

In conclusion, Plaintiffs request the Court to direct Defendants to develop more specific standards, and a more effective enforcement mechanism, and to limit themselves to voiding only what the Court has voided.

Respectfully submitted,

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1974

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, et al.,

Petitioners,

v.

WILLIAM E. SIMON, Secretary of the Treasury, et al.,

Respondents.

IN SUPPORT OF THE PETITIONER

BRIEF AMICUS CURIAE OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1974

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, et al.,

Petitioners,

v.

WILLIAM E. SIMON, Secretary of the Treasury, et al.,

Respondents.

IN SUPPORT OF THE PETITIONER

BRIEF AMICUS CURIAE OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

INTEREST OF AMICUS CURIAE

The American Public Health Association (APHA) is a national non-governmental organization established in 1872. Its membership of over 50,000 men and women includes physicians, hospital administrators, nurses, and virtually every other type of health worker, as well as increasing numbers of health consumers. The APHA is the largest public health organization in the world.

Although APHA members are involved in a variety of activities in the public health area, they share a concern for the public's welfare—a concern that transcends both economic and professional self-interest. The APHA "does not constitute an 'industry' threatened by programs that place the public good ahead of private or institutional gain." [American Public Health Association Testimony in *Hearings on National Health Insurance Before the House Comm. on Ways and Means,* 93d Cong., 2d Sess., Vol. 5, at 2069 (1974)]. Its concern is with the development of health care to meet the needs of all members of the public.

Over the past several years, the APHA has noted that many private, non profit hospitals[1] in the United States have failed to live up to their ethical and legal obligations to make available free and below-cost care to persons unable to pay established rates. Through resolutions and other organizational activities, the APHA has consistently opposed governmental and private efforts to limit access of certain sectors of the community to free or below-cost care and has called for an expansion of care available to low-income and disadvantaged people, and, in particular, has called on nonprofit hospitals to provide a reasonable volume of services to those unable to pay.

The APHA believes that Revenue Ruling 69-545 restricts the access of the poor to needed hospital services. It is, accordingly, contrary to established federal policy regarding hospital care [enunciated in *e.g.*, 42 U.S.C. §291c(e)] and is contrary as well to the principles to which the Association has steadfastly adhered over the

[1]For purposes of this brief the terms private nonprofit hospitals, community hospitals, voluntary hospitals, nongovernmental not-for-profit hospitals, or any combination thereof are used interchangeably.

years. As a result of this ruling, hundreds of thousands of low-income persons, including many of the newly unemployed, will be unable to make use of hospital facilities which had once been available to them. The APHA is deeply disturbed that the IRS apparently brought about this major change in its policies on the basis of erroneous assumptions of fact and without affording health professionals and consumers the opportunity to provide information and comment.

Because of its long history of dedication to and involvement in protecting the public welfare, its lack of any direct financial interest in the outcome of the case and the expertise it has developed in matters concerning hospital administration, the APHA believes that it is in a position to offer important information concerning the issues raised in this case. Amicus believes that had it had the opportunity to present this information to the IRS, the Revenue Ruling which is the subject of this action would never have been enacted. Having obtained the written consent of both parties pursuant to Supreme Court Rule 42 (2), the APHA submits this brief in support of Eastern Kentucky Welfare Rights Organization, *et. al.*, petitioners in 74-1110.

SUMMARY OF THE ARGUMENT

Millions of Americans today lack hospital coverage and are dependent on private, nonprofit hospitals for free and below-cost care. These hospitals were built with the support of private philanthropy and public funds on the understanding that such care would be available to persons unable to pay. For a period of more than 50 years prior to the issuance of Revenue Ruling 69-545, the Internal Revenue Service had been requiring hospitals to provide services to persons unable to pay as a condition

of tax-exempt status under §501(c)(3) of the Internal Revenue Code. This requirement had also been enforced by judicial decisions for a period of 30 years.

The Internal Revenue Service had no authority to eliminate this requirement through a revenue ruling. In so doing, it has undermined the premise on which the private, nonprofit system of hospitals was established, has jeopardized the health of millions of Americans, and has increased the burden on government by giving express approval to and legitimizing the practice of sending non-paying patients to government hospitals.

There has been no change in circumstances sufficient to justify this dramatic shift in federal health policy. Since the cost of hospital care continues to increase, some form of insurance coverage has become essential for most American families in order to pay the cost of hospital care. In 1973, approximately one-tenth of the entire population of the United States was entirely without any such hospital coverage and millions more are inadequately protected. The number of persons without hospital coverage is increasing due to the high unemployment rate. There is no federal legislation on the horizon likely to remedy this gap in hospital coverage.

The Court of Appeals asserted that persons without hospital coverage increasingly have access to hospital services operated directly by governmental bodies. Unfortunately, the trend actually is in the opposite direction. Local government has not been able to keep pace with the increasing costs of hospital care. In some locations, there never have been government hospitals for persons unable to pay. In other locations, such as California, many of these facilities are being phased out, and in some instances, persons just above the Medicaid eligibility

requirements are being turned away from even these governmental facilities.

The current financial position of nonprofit hospitals does not present a barrier to the provision of free and below-cost service. The Medicaid and Medicare programs have improved the financial position of such hospitals, thereby adding to their capacity to provide such services. Furthermore, the free and below-cost service requirement has never required these hospitals to provide such services beyond the extent of their financial ability.

In determining the Medicaid and Medicare reimbursement formulas, Congress determined that hospitals themselves should bear the cost of charity care for other patients. Congress took into consideration the impact Medicaid and Medicare would have in reducing the amount of bad debt and charity service losses incurred by hospitals.

Medicaid and Medicare patients, for whose care the hospitals are fully reimbursed, are not persons unable to pay and cannot be included in fulfillment of the obligation of tax-exempt hospitals to provide charity care.

The requirement that hospitals have an emergency room open to all persons is also not a satisfactory solution to their obligation to persons unable to pay. "Emergency room care" is an ambiguous term which does not set forth any clear obligation of tax-exempt hospitals to persons unable to pay. Moreover, however defined, emergency room care does not meet the needs of the poor for free and below-cost inpatient as well as outpatient hospital services. Such services are not available in, nor appropriate to, the emergency room. The Court of Appeals seemed to imply that the emergency

room should be used as an outpatient clinic. While this use has occurred in the past, it interferes with access of persons with real emergencies to emergency care, and the present trend is to provide outpatient services elsewhere in the hospital or in the community.

Finally, the complete turnabout in the IRS's position on the duty of private, nonprofit hospitals to provide services for persons unable to pay, if proper at all, is a major change in policy that cannot properly be effectuated except through compliance with the Administrative Procedure Act, 5 U.S.C. §551 *et seq.*

ARGUMENT

I.

PRIVATE, NONPROFIT HOSPITALS MUST PROVIDE MEDICAL SERVICES TO PERSONS UNABLE TO PAY, AS THEY HAVE IN THE PAST, IN ORDER TO QUALIFY AS "CHARITABLE" ORGANIZATIONS UNDER §501(c)(3) OF THE INTERNAL REVENUE CODE

Our system of private, nonprofit hospitals was built with the support of private philanthropy and public funds on the premise, understood by all, that these hospitals would make available free and below-cost service for persons unable to pay.[2] The Internal Revenue

[2]The principle on which voluntary hospitals were founded was that financial barriers would not be permitted to deprive a person of necessary service: "Without discussing underlying principles of justice or social administration, we may lay down the principle, generally accepted in this country, that the charges for hospital service should be such as to deprive no one of necessary service. It is in accordance with this principle that municipalities appropriate money for the support of hospitals, and it is this belief that induces philanthropic individuals voluntarily to contribute generous sums toward the erection and maintenance of hospitals. Funds so given

[footnote continued]

Service at an early date recognized the obligation of private, nonprofit hospitals to provide free services to persons unable to pay and uniformly applied this requirement over a period of 50 years. Judicial interpretation of "charitable" under §501(c)(3) of the Internal Revenue Code has held for the last 30 years that such hospitals must provide services to persons unable to pay. The system of private, nonprofit hospitals in the United States has developed to the point where millions of Americans without public or private hospital coverage are dependent on these facilities for free or below-cost care.

Revenue Ruling 69-545, ignoring established case law and the historical development of our health care system, redefined "charitable" as it applies to hospitals to require services to all persons *except* persons unable to pay. This dramatic reversal of federal tax policy not only threatens to destroy the access of millions of Americans to hospital care, but also significantly increases the burdens on government. When private, nonprofit hospitals refuse to provide hospital care to persons unable to pay, there is no place else but government on which the burden of providing such services can fall.

The tradition of private, nonprofit hospitals providing services to indigent persons has its historical roots in the Pennsylvania Hospital, incorporated in 1751 with the support of Benjamin Franklin.[3] On petition of sundry

may properly be used for rich and poor alike; they may with justice be used and consumed by the poor, but if used by the rich, must be used without depleting the funds." S. S. GOLDWATER, ON HOSPITALS 65 (1947).

[3]BENJAMIN FRANKLIN, SOME ACCOUNT OF THE PENNSYLVANIA HOSPITAL 4 (1754) (Reprinted by Institute of the History of Medicine, 1954). The Treasurer of Pennsylvania was

[footnote continued]

inhabitants of the Province of Pennsylvania who represented that individuals would contribute to the support of such a hospital, the House of Representatives passed an Act setting up a special corporation under the name, "Contributors to the Pennsylvania Hospital."[4] Upon raising a sufficient amount of private contributions, the Pennsylvania Hospital received matching funds from the public treasury. The facility was intended to provide medical care in the modern sense of that term. A high quality of hospital care was insured by the decision to take paying patients, who would demand minimum standards of care, as well as taking indigent patients. The conditions in a private, nonprofit hospital such as this were in marked contrast to those in early governmental hospitals, which acquired the reputation of being "pesthouses" where persons came to die. Benjamin Franklin summarized his aspirations for such a hospital as follows:

> In short, a Beggar, in a well regulated Hospital, stands an equal Chance with a Prince in his Palace for a comfortable Subsistence, and an expeditious and effectual Cure of his Diseases.[5]

In keeping with the heritage of the Pennsylvania Hospital, private, nonprofit hospitals in the United States

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authorized to provide two thousand pounds "to be applied to the Founding, Building, and Furnishing" of the hospital after private individuals raised capital stock worth two thousand pounds. *Id* at 11. The hospital was conceived as a facility for short-term medical care. *Id.* at 4. Paying patients were to be admitted. *Id.* at 26. The first year, 24 paying patients and 40 charity patients were admitted, and this pattern of admission was followed thereafter. See E.H.L. CORWIN, THE AMERICAN HOSPITAL 61 (1946).

[4]FRANKLIN, *supra*, note 3, at 4, 5.

[5]BENJAMIN FRANKLIN, SOME ACCOUNT OF THE PENNSYLVANIA HOSPITAL 22 (1754) (Reprinted by Institute of the History of Medicine, 1954).

were able to attract joint funding from public and private sources by continuing to provide care to indigent persons that was usually superior in quality to that provided by many government-operated facilities. The tradition of private, nonprofit hospitals in the United States providing charity care was recognized by the Internal Revenue Service and was the basis on which such hospitals were classified as "charitable" institutions and became eligible to receive tax-exempt contributions from private individuals.

Treasury regulations expressly required hospitals, in addition to the general information required of all applicants for tax-exempt status, to establish by affidavit "whether nonpaying patients are accepted." *See* Regulations 69, §231, Article 511(4) (1926). The reporting requirement was modified by Regulations 101, Art. 101-1(5)[1938] to require hospitals to establish "whether part-pay or non-pay patients are accepted and whether the amounts paid by part-pay patients are more than nominal."[6] These reporting requirements made clear that a hospital entitled to tax-exempt status would have to provide services to persons unable to pay, although this was suggested in the definition of "charitable" as "relief of the poor" in I.T. 1800, II-2 Cum. Bull. 152 (1923).

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[6]Revenue Act of 1938, Ch. 289, 52 Stat. 447. The IRS had stressed the importance of the reporting requirement and stated that in order to determine the tax-exempt status of an organization seeking exemption, it was essential that this information be furnished. MIM. 3537, CUM. BULL. 81 (1927). Subsequent to the Revenue Act of 1938, printed forms were used to gather this kind of information.

While local government often reimbursed private, nonprofit hospitals for the expense of caring for "public charges," the cost of providing care for the medically indigent has been the responsibility of the hospital itself, which absorbed the cost of this care as part of its obligation to provide free and below-cost services to persons unable to pay. Public charges or welfare recipients were persons who were not self-supporting and received assistance for the basic necessities of life from government. Medically indigent persons are persons who can afford their own food, clothing and shelter, but are unable to afford their medical expenses.[7]

The readiness of private nonprofit hospitals to admit many persons unable to pay was a major factor not only in attracting philanthropic contributions, but also in the decision frequently made by a county or municipal government to utilize the facilities for "public charges" instead of building a separate county or municipal hospital.[8] Private, nonprofit hospitals in turn benefited from reimbursement for "public charges" which helped to keep them financially solvent, as they were never able to sustain operations solely from private philanthropy.[9] It has been estimated that in providing hospital care for "public charges" and for persons who were provided hospital services on a free or below-cost basis, the voluntary hospitals were providing on a nation-wide basis 70 percent of all hospital care that indigents received.[10] Mutual advantages for both voluntary hospitals and state

[7]S. HARRIS, THE ECONOMICS OF HEALTH CARE: FINANCE AND DELIVERY 418 (1975).

[8]E.H.L. CORWIN, THE AMERICAN HOSPITAL 68 (1946).

[9]*Id.* at 58, 194.

[10]*Id.* at 195.

and local government resulted from these arrangements.[11]

A major benefit to local government in supporting private, nonprofit hospitals through reimbursement for "public charges" or other forms of assistance was that the medically indigent received free or below-cost care at no expense to the public treasury. For instance, New York was among the few municipalities that provided coverage for some but not all medically indigent persons who could meet eligibility criteria. A study which traced governmental assistance to private, nonprofit hospitals in New York back to colonial times found that the private, nonprofit hospitals treated many medically indigent persons without expectation of reimbursement from any source. For every seven medically indigent patients treated by the private, nonprofit hospitals, the City reimbursed the hospital for the care of three of the patients, while the hospital absorbed the expense of providing care for the remaining four persons.[12]

Many communities, especially in rural areas, were urged to and did rely on private, nonprofit hospitals to provide care for indigent persons instead of constructing public facilities. The Commission on Hospital Care, organized under the auspices of the American Hospital Association, after an extensive analysis of the hospital situation, made just such a recommendation.[13] The Commission urged that small communities should not build both a public and a private hospital for the reason

[11]*Id.* at 194-195.

[12]H. KLARMAN, HOSPITAL CARE IN NEW YORK CITY 410 (1963).

[13]COMMISSION ON HOSPITAL CARE, HOSPITAL CARE IN THE UNITED STATES 17-18 (1947).

that such duplication of facilities or services should be avoided in order to assure that one hospital could be built that would reach optimal size.[14] The Commission recommended against building or expanding a government facility in areas which already had a private, nonprofit hospital.[15] In communities without governmental facilities, the local private, nonprofit hospital became the hospital of last resort for persons unable to pay for hospital care.

Judicial construction of the free and below-cost service obligation of private, nonprofit hospitals developed on a case by case basis, which provided different courts the opportunity to observe the role of these hospitals in a variety of different communities and at different times in the development of our system of private, nonprofit hospitals. These cases are rich in detail concerning the various aspects of the problem of providing hospital care for urban, as compared to rural communities, and in areas with many hospitals, as compared to locations that are served by only a few hospitals. *See* the cases cited by the Court of Appeals, 506 F.2d 1278, 1287. Despite the scrutiny of a large number of different factual circumstances, virtually every judicial consideration of the construction of "charitable" as it applies to hospitals agreed that private, nonprofit hospitals are required to provide services to persons unable to pay. Revenue Ruling 56-185 summarized the collective wisdom of these cases, and correctly concluded that "charitable" status is reserved for hospitals which provide free and below-cost services to persons unable to pay. In reversing this requirement by issuing Revenue Ruling 69-545, without

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[14] *Id.* at 68.

[15] *Id.* at 67.

opportunity for public debate or comment, the IRS went beyond its lawful authority.

Revenue Ruling 69-545 adds to, rather than lessens, the burdens of government by specifically encouraging private, nonprofit hospitals to "dump" their charity patients on the local public hospitals. This practice has been recognized to be harmful both to government hospitals and to the poor.[16] The "dumping" policy is expressed in Revenue Ruling 69-545 as follows:

> The hospital operates a full time emergency room and no one requiring emergency care is denied treatment. . . . Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients.

Disposal of unwanted indigent patients by private, nonprofit hospitals is precisely the type of activity that was disapproved in *Sonora Community Hospital*, 46 T.C. 519, 524 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968) and was a factor in the denial of tax-exempt status to that hospital:

> Its practice was to refer charity patients to the County Hospital, and on occasion when a charity patient was admitted in an emergency it would have him transferred when circumstances permitted to the County Hospital.

As the 1959 regulation [Treasury Regulation, §1.501(c)(3)-1(d)(2)] defining "charitable" recognizes, organizations are granted tax-exempt status to relieve

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[16] See Roemer & Mera, *Patient Dumping and Other Voluntary Agency Contributions to Public Agency Problems,*" 11 MED. CARE 30 (Jan.-Feb. 1973). Woodward, *Poor Hurt by Transfers, Doctor Says*, Washington Post, Sept. 30, 1971, at 17, col. 1.

government of some of its burdens and not to increase them.

Our system of hospital care has relied on private, nonprofit hospitals to absorb the cost of providing services to persons unable to pay. If they fail to fulfill this obligation, many persons may for the first time be without access to hospital care of any kind. After 50 years of private philanthropy and public funds being invested in these facilities, to the exclusion of alternative modes of financing hospital care, a reversal in the meaning of "charitable" as applied to hospitals cannot be justified under any circumstances that presently exist.

II.

THE ISSUANCE OF REVENUE RULING 69-545 CANNOT BE JUSTIFIED BY A CHANGE IN CIRCUMSTANCES.

In sustaining Revenue Ruling 69-545, the Court of Appeals sanctioned a fundamental shift in federal health policy: elimination of the requirement that hospitals qualifying for §501(c)(3) status accept patients in need of hospital care who are unable to pay for all or part of the cost of such services. In so ruling, the Court below appears to have given great weight to what it perceived to be "changing economic, social and technological precepts and values of contemporary society," 506 F.2d 1278, 1288. In particular, the Court made a number of assumptions—unsupported by the record—concerning the financing and delivery of health care to the poor.[17]

[17]The Court reasoned as follows: "In the field of health care, the changes have been dramatic. Hospitals in the early part of this nation's history were almshouses supported by philanthropy and serving almost exclusively the sick poor. Today, hospitals are the primary community health facility for both rich and poor. Philan-

[footnote continued]

Amicus respectfully submits that these assumptions have no basis in fact and reflect an erroneous view of the circumstances in which millions of low-income persons find themselves today.

It is true that health care financing and delivery have undergone changes during the past few decades. The costs of hospital services have risen precipitously, and the number of persons with public or private hospital insurance coverage for such expenses has increased markedly. However, these developments have not significantly altered the dependence of millions of poor, working poor, and other persons without hospital coverage upon free or below-cost hospital services. These families and individuals simply cannot afford the high cost of hospital care. In many areas, no public hospital alternative exists. And where such facilities do operate, years of underfinancing and neglect have frequently resulted in inadequate staffing, overcrowding, and substantial deterioration of the physical plant and equipment. At the same

throphy accounts for only a minute percentage of the hospital's total operating costs. Those costs have soared in recent years as modernization of equipment and facilities is necessitated by the advances in medical science and technology. *The institution of Medicare and Medicaid in the last decade, combined with the rapid growth of medical and hospital insurance has greatly reduced the number of poor people requiring free or below-cost hospital services.* Much of that decrease has been realized since the promulgation of Revenue Ruling 56-185. *Moreover, increasingly counties and other political subdivisions are providing nonemergency hospitalization and medical care for those unable to pay.* Thus, it appears that the rationale upon which the limited definition of "charitable" was predicated has largely disappeared. To continue to base the "charitable" status of a hospital strictly on the relief it provides for the poor fails to account for these major changes in the area of health care." *Eastern Kentucky Welfare Rights Organization v. Simon*, 506 F.2d 1278, 1288-89 (D.C.Cir. 1974) (footnotes omitted, emphasis added).

time, many private nonprofit hospitals have enhanced their financial positions considerably. In sum, neither the need for free and below-cost services, nor the capacity of private, nonprofit hospitals to deliver such care, has by any means disappeared.

A. Millions of Americans Remain Wholly Dependent Upon Private, Nonprofit Hospitals for Free and Below-Cost Services.

It is true, as the Court below suggests, that Medicaid, 42 U.S.C. §1396 *et seq.* and to a lesser extent Medicare, 42 U.S.C. §1395 *et seq.*, have made hospital coverage available to many low-income persons who would otherwise be without protection.[18] What the Court overlooked, and what this case concerns, is that portion of the populace which "falls into the cracks" between Medicare, Medicaid, and private health insurance coverage. Because the overlap between public and private coverage is not known,[19] the number of persons without economic protection against the costs of hospitalization can only be estimated. Amicus submits that in 1973, prior to the current rise in unemployment figures, the number of persons so situated fell in the neighborhood of 20 to 25 million—roughly one-tenth of the population.[20] Revenue Ruling 69-545 has left this class of families and individuals totally exposed to the "astronomical costs of hospitalization which bear so heavily on the resources of most Americans," *Memorial Hospital v. Maricopa County*, 415 U.S. 250, 265 (1974).

In order to appreciate fully the devastating impact of Revenue Ruling 69-545 on millions of poor and working poor, a basic understanding of major trends in the cost and financing of hospital services is necessary. First, the price of hospital services has risen dramatically over the past two and one half decades, and continues to do so. In fiscal year 1950, the total expense per patient day in private, nonprofit hospitals was $15.62; by fiscal year 1972, this figure had increased more than 600 percent to $105.21.[21] This inflationary pattern shows no sign of abating. During the first eleven months following the expiration of price controls on the health care industry,[22] hospital service charges rose 15.4 percent; hospital

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[18]Since the advent of Medicaid, utilization of physician services by the poor has increased markedly. See B. BLECHMAN, E. GRAMLICH & R. HARTMAN, SETTING NATIONAL PRIORITIES: THE 1975 BUDGET 210-11 (1974).

[19]Mueller, *Private Health Insurance in 1973: A Review of Coverage, Enrollment, and Financial Experience*, 38 SOCIAL SECURITY BULL. 21, 22 (Feb. 1975).

[20]According to the Office of Research and Statistics of the Social Security Administration, some 41 million Americans under age 65 had no private health insurance protection against the expense of hospitalization in 1973. *Id.* at 21. An estimated 17.4 million of these (20.9 million total Medicaid beneficiaries less 3.5 million aged 65 and over) were covered by Medicaid. *Id.* at 22. Thus, roughly 23.6 million Americans under 65 had no private health insurance or Medicaid coverage. Some of these, in turn, had hospital coverage under programs such as workmen's compensation and the civilian health care program for the armed services (CHAMPUS), but these numbers were not large. Given the approximate nature of these aggregate statistics, it seems reasonable to conclude that somewhere between 20 to 25 million persons had no protection against hospital costs in 1973.

[footnote continued]

[21]Davis, "Lessons of Medicare and Medicaid for National Health Insurance," in *Hearings on National Health Insurance and Health Care Before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce*, 93d Cong., 1st & 2d Sess., 93-69, ser. at 210 (1974).

[22]Under the Economic Stabilization Program, implemented under the authority contained in the Economic Stabilization Act

[footnote continued]

semi-private room rates climbed 19.1 percent.[23] During this same period, the increase in the consumer price index for all goods and services was considerably lower—9.0 percent.[24] Between 1966 and 1974, the cost per patient day in nonprofit hospitals, adjusted to account for the volume of outpatient visits, climbed from $43.58 to $110.77.[25] There is no sound reason to believe that this inflationary trend will change substantially in the foreseeable future.[26]

As the price of hospital services has increased, the importance of third-party payments for such services has grown. Of the total amount of personal hospital expenditures in fiscal year 1950, some 34 percent was paid out of pocket by consumers directly to hospitals; payments to hospitals by third parties, principally public and private

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of 1970, Pub. L. No. 91-379, Title II, 84 Stat. 799, hospital service prices were controlled from the period August 1971 through April 1974.

[23]The period to which these figures apply is May 1974, through April 1975. U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, MONTHLY LABOR REVIEW 102 (1975).

[24]*Id.* at 97.

[25]Worthington, *National Health Expenditures,* 1929-74, 38 SOCIAL SECURITY BULL. 3, 4 (Feb. 1975).

[26]It is widely recognized by independent analysts that, absent reinstatement of price controls on the health industry or major structural changes in the delivery and financing of health care, the costs of hospital and medical services cannot be effectively contained. See, e.g., Robbins, *Health Costs—A One-Way Street,* Wall Street Journal, May 8, 1975, at 10, col. 3; Statement of InterStudy in *Hearings on National Health Insurance Before the House Comm. on Ways and Means,* 93d Cong., 2d Sess., Vol. 3, at 1289-1324 (1974); V. FUCHS, WHO SHALL LIVE? 94-104, 149-151 (1974). Neither price controls nor major structural changes seem imminent.

insurance, accounted for the remaining 66 percent.[27] By fiscal year 1972, direct consumer payments accounted for only 8 percent of all personal hospital expenditures at community hospitals; the remaining 92 percent of such payments came from third parties.[28] Thus, while more and more families and individuals have obtained third-party coverage to protect themselves against the continuously escalating price of hospital services, those without such coverage find themselves exposed to ever-increasing financial risk.

Third-party payors, in turn, fall into two broad categories: public and private. The two principal public programs which provide hospital services financing to eligible beneficiaries are Medicare and Medicaid. Medicare is a program of health insurance for aged and disabled Social Security beneficiaries financed and administered by the federal government.[29] As of July 1, 1973, some 21.5 million persons aged 65 and over, as well as 1.7 million disabled, were eligible for hospital insurance benefits under Part A of Medicare.[30] Medicaid is the state-administered program of medical assistance for low-income persons who are recipients of either Aid to Families with Dependent Children (AFDC), 42 U.S.C. §601 *et seq.*, or the Supplemental Security Income

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[27]*Hearings on National Health Insurance and Health Care, supra,* note 21, at 210.

[28]*Id.*

[29]For a brief description of the Medicare program, see STAFF OF HOUSE COMM. ON WAYS AND MEANS, 93 Cong., 2d Sess., NATIONAL HEALTH INSURANCE RESOURCE BOOK 429-33 (1974).

[30]Ruther, *Medicare, Number of Persons Insured, July 1, 1973,* 38 SOCIAL SECURITY BULL. 33 (June, 1975).

Program for the aged, blind, or disabled (SSI), 42 U.S.C. §1381 *et seq.*[31] All states electing to participate in Medicaid must share with the federal government the cost of certain medical services, including hospital care. 42 U.S.C. §1396d(a)(1). In 1973, some 23.5 million persons were eligible for medical assistance; it is estimated that this figure will increase to 28.6 million in 1975.[32]

The major private third-party payors for hospital services are the commercial indemnity insurers and the non-profit service benefit plans.[33] As of December 31, 1973, prior to the current recession, an estimated 146 million persons under age 65 had some form of hospital coverage under private health insurance plans,[34] primarily in the form of group health insurance policies offered unilaterally or jointly by employers or employees. As of April, 1972, an estimated 46 million full-time workers—some 70 percent of the full-time civilian labor force—had employment-related group health insurance coverage.[35]

Notwithstanding the implementation of Medicaid and Medicare and the expansion of private health insurance

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[31]For a brief description of the Medicaid program, see NATIONAL HEALTH INSURANCE RESOURCE BOOK, *supra*, note 29, at 487-90.

[32]*Id.* at 491.

[33]For a brief discussion of private health insurers, see J. KRIZAY & A. WILSON, THE PATIENT AS CONSUMER (1974).

[34]Mueller, *supra* note 19, at 24. This is the estimate of the Social Security Administration's highly regarded Office of Research and Statistics as to the net number of different persons covered; the estimates of the Health Insurance Association of America are substantially higher.

[35]Kolodrubetz, *Group Health Insurance Coverage of Full-Time Employees*, 1972, 37 SOCIAL SECURITY BULL. 17 (April 1974).

enrollment, millions of Americans lack any third-party coverage whatsoever for the often crushing expense of hospitalization. Due to restrictive eligibility standards adopted by a number of states,[36] Medicaid fails to reach many low-income individuals and families. In 1974, an estimated 9 million poor people were excluded from medical assistance.[37] Similarly, many of the poor and working poor have been passed over by the growth in private hospital insurance coverage. In 1970, some 47 percent of those persons earning between $3,000 and $5,000 per year had no private hospital insurance coverage at all; of those earning between $5,000 and $10,000 per year, approximately 20 percent had no private hospital insurance.[38] As a result, roughly one out of every ten Americans has no hospital coverage whatsoever.[39] And many of those covered find themselves inadequately protected against the financial burdens associated with hospitalization.[40]

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[36]See, e.g., Butler & Schneider, "Analysis of Title II of S.2513 (Long-Ribicoff)—Proposal for National Health Insurance," in *Hearings on National Health Insurance Before the House Comm. on Ways and Means*, 93d Cong., 2d Sess., Vol. 7, at 3116-18 (1974).

[37]Mueller, *supra* note 19, at 22.

[38]Statement of Perrin in *Hearings on National Health Insurance and Health Care Before the Subcomm. on Public Health and Environment of the Comm. on Interstate and Foreign Commerce*, 93d Cong., 1st & 2d Sess., Ser. 93-69, at 342, Table 2 (1974).

[39]*Supra* note 20.

[40]As the costs of hospital care have climbed in recent years, the protection afforded by private health insurance has declined. In 1971, private health insurance met 82 percent of consumer expenditures for hospital care; by 1973, the proportion of hospital expenditures met by health insurance had dropped to 75 percent. Mueller, *supra* note 19, at 37. Thus, those persons with private

[footnote continued]

Obviously the class of persons dependent upon private, nonprofit hospitals for free and below-cost services is large even when employment is high. When economic conditions deteriorate, however, this class can expand rapidly, as our current dilemma illustrates. Between December 1973 and March 1975, the official unemployment rate rose from 4.7 percent to 8.7 percent.[41] Because most private health insurance coverage is employment-related, loss of one's job is usually followed by loss of one's health insurance.[42] Thus, as of March 1975, some 7.5 million workers were unemployed. About 6 million of these, and some 9.4 million of their dependents, were receiving unemployment compensation at that time; however, of these 15.4 million persons, nearly 10

health insurance coverage of some kind must meet, on average, one fourth of their rising hospital bills out of pocket, usually in the form of deductibles and/or coinsurance. Moreover, the extent to which private health insurance policies protect the insured against financial hardship of hospitalization expenses varies enormously. Those with individual health insurance policies usually have less complete coverage purchased at greater expense than those enrolled under employment-related group policies. KRIZAY & WILSON, *supra* note 33, at 5. And workers in low-wage industries tend to have group health insurance coverage (when they have it at all) that is far less comprehensive than that enjoyed by employees in higher-wage industries. *Id.* at 32-33. A low-income worker with limited hospital coverage may therefore find himself in need of free or below cost services if a serious illness in his family requires extended hospitalization, exhausting his insurance benefits before the need for hospital services has ended.

[41]H.R. REP. NO. 171, Emergency Health Insurance Extension Act of 1975, 94th Cong., 1st Sess. 20 (1975).

[42]Most employer-related health insurance coverage terminates when the worker is laid off; under nearly three-fourths of such policies, benefits are discontinued within the 30-day period following layoff. *Id.* at 24-25.

million had no health insurance coverage.[43] The remaining 1.5 million unemployed workers, and an unknown number of their dependents, were not receiving any unemployment compensation and, in all likelihood, had lost their health insurance coverage.[44] Unable to afford private insurance,[45] and ineligible for Medicare or Medicaid,[46] more than ten million recently unemployed

[43]*Id.* at 30.

[44]Those individuals and families who have lost their source of income due to unemployment and in addition are unable to offset this loss even partially through unemployment compensation will rarely be in a position to continue payment of their private health insurance premiums—assuming, of course, that they were covered while employed.

[45]Nearly all employment-related health insurance policies contain "conversion options" which enable a worker who has lost his job (and therefore his membership in the insured group) to obtain coverage on an individual basis. However, the premium for individual coverage is usually 30 to 50 percent higher than that for the group policy, and the scope of coverage is usually much more limited. The higher premium levels associated with conversion usually preclude unemployed workers, with only limited financial resources, from exercising this option. Thus, most lose their coverage within a month after layoff. *Id.* at 26.

[46]In a recent report on emergency health insurance legislation, the House Committee on Interstate and Foreign Commerce explored the limited public alternatives available to the recently unemployed: "Not only do the unemployed generally lose their employment-based health insurance, they are not usually able to obtain alternative coverage under public programs. Half the States preclude male-headed families from receiving Medicaid. In those states which cover male-headed families, Federal law prohibits unemployment compensation recipients from receiving AFDC payments and, by cross-reference, Medicaid. Thus, while dependent children under 21 might be able to obtain coverage in some States, most unemployment compensation recipients cannot qualify for

[footnote continued]

workers and their families have joined the 20 or so million who are totally exposed to the financial hardship associated with hospitalization.

Clearly, circumstances have not improved significantly for these citizens. Nor are they likely to change in the near future. Realistically viewed, the prospects for remedial legislative intervention are dim. Congress recently gave serious consideration to various measures designed to alleviate the plight of the millions of recently unemployed and their dependents who are without health insurance coverage.[47] Despite strong support from organized labor and numerous health interest groups, legislative proposals addressed to this problem have languished in the face of jurisdictional disputes and concern over costs.[48] And even if some form of health insurance coverage for the recently unemployed is by some chance enacted in the near future, it is unlikely to solve the difficulties faced by large numbers of the poor

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Medicaid. Medicare covers only the aged and disabled (with a two-year waiting period for the disabled). Finally, many communities lack public housing or physician care, and where such care is available it is often so oversubscribed that new users find it essentially unavailable." *Id.* at 26.

[47]The major policy approaches to this issue are embodied in the following bills, introduced during the 1st Session of the 94th Congress: H.R. 3208, H.R. 4004, and H.R. 5000. For a discussion of these measures and their strengths and weaknesses, see Schechter, *Health Insurance for the Jobless*, Washington Post, April 6, 1975, at C-5, col. 1.

[48]See Iglehart, *Health Report/Jobless Medical Aid Debate Focuses on Financing Method*, 7 NAT. J. REP. 457 (1975); Iglehart, *Health Report/Feuding, Ford Opposition Peril Jobless Health Insurance*, 7 NAT. J. REP. 592 (1975); Iglehart, *Health Report/Speaker Supports Rogers in Dispute with Ways and Means*, 7 NAT. J. REP. 773 (1975).

and working poor. The leading proposals are all temporary in nature and would make health benefits available only to those jobless workers eligible for unemployment compensation who had health insurance coverage while employed.[49] The number of persons who would benefit from this legislation, while not insignificant, falls far short of the number of dependent upon private nonprofit hospitals for free and below-cost services.

Similarly, it is highly unlikely that a broader program of health care financing will be enacted. Many observers, including Amicus, take the position that the dependence of the poor, working poor, and medically indigent on charitable contributions for access to hospital services can only be eliminated through the enactment of a national health plan under which the entire population is entitled to comprehensive health coverage.[50] Such a scheme, it is hoped, would finance hospital and medical services for the millions who have fallen into the gap between public and private coverage, services which are now financed in part through charitable contributions. Yet the prospects for the passage of such legislation do not appear good. Given the inability of the 94th Congress to pass legislation providing health insurance coverage for the unemployed, the possibility of obtaining a consensus on a far more expensive national health insurance plan is negligi-

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[49]The only exception to this pattern is the substitute amendment for H.R. 5970, 94th Cong., 1st Sess., offered by the House Committee on Interstate and Foreign Commerce, which would extend Medicaid benefits to those receiving unemployment compensation who did not have health insurance coverage while employed.

[50]American Public Health Association Testimony in *Hearings on National Health Insurance Before the House Comm. on Ways and Means*, 93d Cong., 2d Sess., Vol. 5, at 2069 (1974).

ble.[51] And even if such a program were somehow enacted in the near future, there is no assurance whatsoever that it would obviate the need of the poor and working poor for charity care.[52]

B. The Court of Appeals Erred in its Assumption That Government-Operated Hospital Facilities are Expanding to Provide More Services to Persons Unable to Pay.

Historically, some county and local governments have undertaken financial and managerial responsibility for the provision of inpatient and outpatient hospital services to indigents residing within their boundaries.[53] However, contrary to the assumption of the Court below, government-operated hospital care for those unable to pay is decreasing, not increasing in scope. In many areas of the country, public hospital facilities are, and always have been, nonexistent;[54] the local indigent population must continue to rely on private, nonprofit hospitals for necessary health care services on a free or below-cost basis. And in other areas of the country, county and local

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[51]This view is shared by most knowledgeable observers. See e.g., Iglehart, *Health Report/Economy taking steam from national insurance drive*, 7 NAT. J. REP. 93 (1975).

[52]See Butler & Schneider, *supra* note 36, at 3114.

[53]Between 1966 and 1974 the percentage of national health care expenditures financed through public funds increased from 25.7 percent to 39.6 percent. Worthington, *supra* note 25, at 5. During the same period the aggregate contribution to personal health care expenditures from state and local sources increased from $4,542 billion to $10,895 billion. *Id.* at 16. *Memorial Hospital v. Maricopa County*, 415 U.S. 250 (1974), may cause further increases in state and local contributions toward the provision of health care services for short-term residents.

[54]H.R. REP. NO. 171, *supra* note 41, at 26.

governments have phased out their public facilities altogether or are in the process of so doing. In these jurisdictions, the dependence of the poor and working poor on private, nonprofit hospitals for free and below-cost care has demonstrably increased.

Consider, by way of example, recent developments in California, where statutory responsibility for provision of hospital and medical care to indigents lies with the counties.[55] Historically, counties had chosen to meet this obligation by establishing and maintaining hospitals, and a network of some 49 facilities evolved. In recent years, however, some financially-pressed counties have sought to eliminate the mounting deficits associated with public hospital operations by closing the hospitals altogether. Thus, as of early 1975, 8 counties had closed their hospitals, and 5 more were on the verge of taking the same action.[56] Where such closings occur, the private, nonprofit hospitals become the sole source of hospital services for the uncovered poor and working poor. When these private institutions refuse to make free or below-cost services available, those persons unable to pay or have payment made on their behalf must either forego the care or travel to a neighboring county with the hope—and nothing more—of obtaining treatment from a public or private facility there.

Where states and their political subdivisions continue to operate public hospitals, they have often failed to provide the financial support necessary to assure the maintenance of acceptable standards in the quality of

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[55]CAL. WEL. & INST'NS. CODE, §17000 (WEST 1972).

[56]E. BLAKE & T. BODENHEIMER, CLOSING THE DOORS ON THE POOR: THE DISMANTLING OF CALIFORNIA'S COUNTY HOSPITALS 61-71 (1975).

care.[57] Often, the overcrowding and deterioration of these facilities is aggravated when nonprofit, tax-exempt hospitals divert all persons unable to pay the full charge for their services to the public hospital.[58] The resulting quality deficiencies have recently been the focus of strikes by many of the physicians who staff these facilities.[59] In recognition of these shortcomings, Congress last year enacted legislation which, *inter alia*, authorizes the appropriation of funds to assist publicly-owned or operated facilities to bring themselves into compliance with applicable licensure and accreditation standards.[60] It does not appear, however, that any

[57]Mann, *Hospital Shortcomings Cited*, Washington Post, June 12, 1975, at 1, col. 1; Andelman, *City Hospital Agency Nearing Insolvency*, N.Y. Times, Jan. 5, 1975, at 1, col. 5; LARGE URBAN PUBLIC HOSPITAL AMBULATORY SERVICES PROJECT, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA AT LOS ANGELES, THE FINANCIAL STATUS OF THE LARGE URBAN PUBLIC HOSPITAL: THE EXPENSE, REVENUE AND BUDGET RELATIONSHIP 2-6 (1971).

[58]*Supra*, note 16.

[59]See N.Y. Times, Mar. 18, 1975, at 50, col. 4; L.A. Times, May 11, 1975, at 1, col. 5.

[60]Section 1625(a)(2) of the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 2 U.S. Code Cong. & Admin. News 2584 (1975). In explaining the purposes of this section, the Senate Committee on Labor and Public Welfare observed: "Evidence presented at hearings before the Health Subcommittee indicates that as a class, large urban hospitals are in greatest need of modernization and have the fewest sources of funds, other than Federal grants, to undertake such needed updating and upgrading of facilities. Members of the Committee have visited many urban hospitals personally, and have observed first-hand the antiquated, overcrowded, dangerous, and degrading state of many of our large hospitals. In the view of the Committee, it is the responsibility of the Federal government to intervene in this sorry state of affairs." S. REP. NO. 1285, 93d Cong., 2d Sess., 4 U.S. Code. Cong. & Admin. News 7842, 7898 (1975).

monies will actually be appropriated for such purposes in the foreseeable future.[61]

Even where public hospital facilities are capable of providing care of acceptable quality, cost-conscious county or municipal governments often impose restrictions on eligibility for such services which exclude many low-income persons who have no other hospitalization coverage. This Court recently overturned one such restriction, holding that an Arizona county could not constitutionally condition the receipt of nonemergency hospitalization and medical care upon one year's residence, *Memorial Hospital v. Maricopa County*, 415 U.S. 250 (1974). And in California, several counties have established income eligibility levels that are coterminous with those of the State's Medicaid program; thus, the many families living in these counties who earn slightly more than the Medicaid income level but do not have private health insurance are excluded from the public facility.[62] The need of such persons for charity care is equally as pressing as the need of those residing in areas where public facilities are either non-existent or overcrowded.

[61]Although the minimum authorization level for such project grants for Fiscal Year 1976 is 22 percent of $130 million, or $28.6 million, the President's F.Y. 1976 Budget requested no appropriations under this authority. INSTITUTE OF MEDICINE, THE ADMINISTRATION'S 1976 BUDGET: THE HEALTH BUDGET 25 (1975).

[62]LEGISLATIVE STAFF TASK FORCE ON U.C. MEDICAL EDUCATION PROGRAMS, REPORT TO: ASSEMBLY WAYS & MEANS COMMITTEE AND SENATE FINANCE COMMITTEE, IV-4, 1975-1976 REGULAR SESS. CALIF. LEGISLATURE (1975).

C. The Court of Appeals Erred in Assuming That Private, Nonprofit Hospitals are not in a Financial Position to Deliver Free and Below-Cost Services to Persons Unable to pay.

Underlying the Court of Appeals' decision is the assumption that an increase in the costs of capital, labor, and supplies, combined with a reduction in the amount of philanthropic contributions, has largely eroded the financial capacity of all private, nonprofit hospitals to deliver free or below-cost services. This assumption, in turn, implies that continued application of Revenue Ruling 56-185 would undermine the fiscal solvency of such valuable community resources, perhaps driving some to bankruptcy. Amicus respectfully submits that the available evidence does not support either of these assumptions and cannot justify abandonment of the federal health policy embodied in Revenue Ruling 56-185.

For obvious reasons, neither Amicus nor the class of low-income Americans represented by Plaintiffs herein has any interest in undermining the ability of needed private, nonprofit hospitals to deliver appropriate, high quality emergency and nonemergency care. Nor would reversal of the ruling of the Court below, as urged by Amicus, produce such a result. The free and below-cost service requirement contained in Revenue Ruling 56-185 expressly applies "only to the extent of [the tax-exempt hospital's] financial ability." Thus, even if it intended to do so, the Internal Revenue Service could not, consistent with this ruling, force a tax-exempt hospital to jeopardize its fiscal solvency, by providing excessive amounts of free care to indigents. Amicus has no knowledge of any private, nonprofit hospitals which were forced into

bankruptcy by providing excessive amounts of free care to indigents under Revenue Ruling 56-185.[63]

The capacity of a private, nonprofit hospital to provide free or below-cost services to indigents is measured by the bottom line—*i.e.*, the excess of revenues over expenses, often termed "net income." The greater the net income, the greater the hospital's capacity to deliver free services.[64] The size of a hospital's net income, in turn, is determined by a number of factors, including patient

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[63]While private nonprofit hospitals are by no means immune to bankruptcy, excessive volumes of charity care are not normally the source of financial difficulty. Instead, the evidence suggests that a far more significant factor in determining a private nonprofit hospital's financial condition is surplus bed capacity combined with an increasing reliance on debt as a source of capital. Decreasing occupancy levels compromise a facility's capacity to service its debt and may eventually lead to insolvency. F. SATTLER & M. BENNETT, A STATISTICAL PROFILE OF SHORT-TERM HOSPITALS IN THE UNITED STATES AS OF 1972 48 (1974).

[64]Net income, defined as the excess of revenues over expenses, understates the capacity of a private nonprofit hospital to deliver free and below-cost care to indigents. As explained by a leading authority on hospital economics, a more accurate measure of the discretionary funds available to a hospital is its cash-flow position, or net income plus depreciation expense: "Since hospitals receive a large proportion of their capital funds from government grants and donations, hospital depreciation expenses do not play the same role as depreciation funds in other types of businesses. Typically, hospital depreciation expenses are not funded or restricted to replacement of existing capital facilities, so they may be used for any of several purposes. The excess of revenues over expenses other than depreciation reflects more accurately than net income data, therefore, the pool of funds available to the hospital for future use." Davis, *Community Hospital Expenses and Revenues: Pre-Medicare Inflation*, 35 SOCIAL SECURITY BULL. 3, 14 (Oct. 1972). Future use, of course, could involve the provision of free and below-cost services.

revenues, philanthropic contributions, labor costs, capital expenses, and other operating costs.[65] Each of these factors, in turn, is a function of many other variables.[66] Generalizations regarding the financial positions of private nonprofit hospitals are therefore hazardous, at best. Nonetheless, a few observations should be made for the benefit of the Court.

First, contrary to the apparent assumption of the Court below, there is abundant evidence suggesting that many private, nonprofit hospitals have the financial capacity to provide free or below-cost services to indigents. A study undertaken by the Social Security Administration found that during the period 1961-1971, total revenue of private, nonprofit hospitals rose from $4.7 billion in 1961 to $16.8 billion in 1971, while expenses increased somewhat less, from $4.5 billion to $16.3 billion. Thus, "overall net income grew tremendously," from $91 million in 1961 to $457 million in 1971.[67] Thus, although the individual financial condi-

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[65]Pettengill, *The Financial Position of Private Community Hospitals, 1961-71*, 36 SOCIAL SECURITY BULLETIN 3, 4-11 (Nov., 1973).

[66]Patient revenues, for example, are determined by (1) utilization of the hospital's inpatient and outpatient services, (2) the proportion of patients with public or private hospital coverage, (3) the prices paid by third party payors, (4) the prices paid directly by individual patients, (5) hospital size, and (6) types of services offered.

[67]Pettengill, *supra* note 65, at 4-5. Aggregate net income for private nonprofit hospitals in 1972 was $358.1 million. HOSPITAL STATISTICS 102 (1972 ed.). The corresponding figure for 1973 was $333.2 million. HOSPITAL STATISTICS 198 (1974 ed.). This slight decline in net income of all private nonprofit hospitals during 1972 and 1973 reflects in large measure the impact of price

[footnote continued]

tions of many private, nonprofit hospitals have changed in recent decades, some for better, some for worse, Amicus submits that the improved financial position of private, nonprofit hospitals in the aggregate cannot justify the fundamental reversal in federal health policy undertaken by the Internal Revenue Service in 1969.

Elimination of the requirement that private, nonprofit hospitals provide free and below-cost services to the poor in order to qualify for charitable, tax-exempt status removed a cornerstone from the system by which hospital services for the poor are financed in this country. Currently, the costs of providing "charity care"[68] are shared by the public and private sectors. The public

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controls under the Economic Stabilization Program, *supra* note 22. Comparable data for 1974 will reflect the expiration of price controls but will not be available until August, 1975. However, in light of the 18 percent average increases in daily room rates during that period, it may reasonably be anticipated that hospital revenues will increase, producing a more favorable net income picture. Moreover, notwithstanding the decrease during 1972 and 1973, aggregate net income remained at well over $325 million each year, indicating that many private nonprofit hospitals were in a financial position to provide free and below-cost care to indigents. And again, net income is a conservative measure of the discretionary funds available to nonprofit hospitals, *supra* note 64.

[68]For purposes of assessing a hospital's capacity to deliver free and below-cost services to those unable to pay, it is essential to distinguish between "charity care" and "bad debts." The former term refers to the value of outpatient or inpatient care rendered to indigent or medically indigent patients at no charge or at a rate below normal charge. In contrast, the term "bad debts" refers to the value of outpatient care rendered to individuals other than indigents or medical indigents for which payment cannot be collected. While hospitals sometimes combine these costs for purposes of third-party reimbursement, the obligation at issue here concerns only "charity care," not "bad debts."

sector subsidizes the purchase of hospital care by large numbers of indigents, principally through Medicaid[69] and, to a lesser extent, through Medicare. A portion of the costs of providing care to indigents not covered by these public programs has traditionally been, and continues to be, borne by the paying patients of private, nonprofit hospitals.[70] The remainder is met by philanthropic contributions which, until the issuance of Revenue Ruling 69-545, were stimulated by tax incentives designed to benefit those unable to pay while at the same time lessening the burdens of government.

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[69]One state, Arizona, still does not participate in Medicaid. Thus, private nonprofit hospitals in that state do not have the benefit of Medicaid reimbursement for services rendered to persons who would be eligible were the program in operation. It is therefore understandable that appellant in *Memorial Hospital v. Maricopa County*, 415 U.S. 250, 265 (1974), found itself in "precarious financial straits." The circumstances described in that case, however, do not obtain in any other state, where the provision of care to indigents is financed in part by Medicaid.

[70]From the standpoint of the hospital, paying patients fall into two major reimbursement categories: those who pay "reasonable costs," and those who pay "charges." Medicare and Medicaid beneficiaries, as well as many Blue Cross plan subscribers, have "reasonable costs" paid on their behalf for covered services. Patients with indemnity insurance coverage, as well as those who self-insure, pay "charges"; this category is often referred to as the "self-pays." Those patients who pay "charges" must usually pay more than those paying "reasonable costs" for the same hospital services. Thus, the self-pays (and philanthropy) tend to bear that portion of the cost of providing free and below-cost services to indigents which is not covered by charitable contributions. Although this subsidy scheme raises serious questions as to the equity of burden as among different classes of patients with different sources of payment, historically this has been, and continues to be, the method for financing free and below-cost services to indigents.

Philanthropic contributions to private, nonprofit hospitals may have declined in recent years in relation to hospital operating costs, but these dollars remain critical to the ability of such facilities to render free and below-cost services.[71] Where a nonprofit hospital so chooses, it can solicit charitable contributions that are either unrestricted or specifically designated for the provision of free or below-cost services. Indeed, many private, nonprofit hospitals have done so in the past. As the Vice President of the major health-oriented private foundation recently observed.

> . . . [p]rivate philanthropy often supplies the "critical glue" required to underwrite the losses of hospitals and clinics that serve low-income and poor patients without adequate governmental or private insurance coverage. . . . Although this philanthropic support is small in dollar amount, without it many of these health institutions could not remain financially solvent.[72]

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[71]Hospitals are second only to religious institutions in their capacity to attract the philanthropic dollar, surpassing education, social welfare, and the arts and humanities. Of the $25.15 billion in philanthropy in 1974, $3.9 billion, or 15 percent, went to health and hospitals. AMERICAN ASSOCIATION OF FUND RAISING COUNSEL, GIVING U.S.A.; ANNUAL REPORT, 1975. These philanthropic dollars have a multiplier effect with respect to capital financing; they often function as "seed money" which "enables the hospital to qualify for governmental grants and to reach that level in its capital structure at which it can attract favorable long-term loans, often essential today in the financing of hospital construction." Kernaghan & Manzano, *The Complex Face of Charity*, 49 HOSPITALS 47, 50 (June 1, 1975).

[72]Blendon, *The Changing Role of Private Philanthropy in Health Affairs*, 292 NEW ENG. J. OF MEDICINE 946, 947-48 (1975).

Revenue Ruling 69-545, Amicus submits, will have a serious adverse effect on the incentive of private non-profit hospitals to continue using charitable contributions to finance the provision of free and below-cost care.

Medicare and Medicaid reimbursement policies are predicated on this dual public and private financing of care for the poor. The "reasonable cost" reimbursement formulas for inpatient hospital services under Medicare and Medicaid do not make any allowance for either "charity care" or "bad debts" attributable to those other than program beneficiaries.[73] Congressional intent, as evidenced by the Report of the Senate Finance Committee on the original Medicare and Medicaid legislation, was clearly to absorb some of the charity care burden—*i.e.*, that attributable to program beneficiaries—but to leave the remainder to the private sector:

> In some cases, the charges hospital patients pay include a share of the cost of rendering services to free and part-pay patients as well as a share of uncollectible bills. The committee has given careful consideration to the question of the effect that the proposed program would have on charges to other paying patients. The [Medicare Hospital Insurance program] will reduce the losses of hospital income

[73]42 U.S.C. §1395x(v)(1)(A)(i) requires that the Secretary of HEW, in promulgating regulations defining "reasonable cost," must assure that "under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs . . ." Medicare will, however, pay for bad debts directly attributable to the inability to collect deductible and coinsurance amounts from Medicare beneficiaries. 20 C.F.R. §405.420 (1972).

> from bad debts or for care of free or part-pay aged persons which might otherwise be included in charges to other paying patients by paying the full cost, except for the deductible and coinsurance, for substantially all patients over 65. Under the public assistance programs now existing and even more as they would exist under the provisions of this bill, the Federal Government will make a very substantial contribution toward the medical care of the needy of all ages. . . . [t]he proposed amendments would require, under the medical assistance [Medicaid] and maternal and child health and crippled children programs of the Social Security Act, the payment of the reasonable costs of covered hospital services. This will assist hospitals in reducing income deficits arising out of providing hospital care to persons unable to pay for care.[74]

In taking this approach, the Committee built upon the traditional method of financing charity care in the private sector: through philanthropic contributions, and through charity care factors added onto the charges billed to paying patients. The legislative intent was that Medicare and Medicaid funds reduce the need for these private subsidies but not that federal subsidies replace private subsidies altogether:

> [Medicare and Medicaid] will appreciably reduce the need of hospitals to charge their paying and prepaying patients more than the cost of their services in order to compensate for care rendered to other patients without charge or at less than cost. The bill will thus make a contribution toward rationalizing the distribution of hospital costs and relieving voluntary insurance and prepayment sys-

[74]S. REP. NO. 404, 89th Cong., 1st Sess., 1 U.S. Code Cong. & Admin. News 1977-78 (1965).

> tems, as well as those patients who pay for services at the time when they are rendered, of some part of the burden they now bear for indigent and charity patients.[75]

Congress has reconsidered the definition of "reasonable cost" and Medicare and Medicaid reimbursement policy on charity care on several occasions since the enactment of the initial legislation. However, it has never departed from the basic principle that the costs of free and below-cost care attributable to those other than Medicare or Medicaid beneficiaries were to be borne by other hospital patients and philanthropy.[76] Revenue Ruling

[75] *Id.* at 1978. The Committee's view finds empirical confirmation in the impact of Medicare and Medicaid reimbursement on the net income of private nonprofit hospitals during the first six years of these programs: "The Medicare program, for example, enabled elderly citizens to obtain hospital care and thus contributed to a significant increase in the share of total inpatient days used by persons aged 65 and over. Before the program began in 1966, many persons in that age group received hospital care as charity patients or at reduced rates. To the extent that this situation did exist, losses of hospital revenues in the form of bad debts or charity care for the aged must have been nearly eliminated once the program began. No evidence on the trend in utilization by individuals with low income is available, but the fact that public assistance vendor medical payments went from $0.1 billion to $1.6 billion during the decade suggests that Medicaid probably had the same kind of effect on hospital revenues, though perhaps not to the same degree." Pettengill, *supra* note 65, at 7-8.

[76] Congress considered and amended the "reasonable cost" formulas under Medicare and Medicaid in passing the Social Security Amendments of 1972, Pub. L. No. 92-603, but left undisturbed the prohibition against reimbursement of participating providers for the costs of charity care rendered to those indigents not eligible for Medicaid or Medicare. Since the enactment of Medicare and Medicaid, this clear Congressional insistence on

[footnote continued]

69-545 is, of course, wholly inconsistent with this legislative scheme, since it eliminates the tax incentives for these private subsidies.

Finally, creation of incentives for allocating philanthropic resources toward the provision of free and below cost services, as would occur under Revenue Ruling 56-185, has much to recommend it from the standpoint of national health policy. To the extent that charitable contributions are unrestricted, hospitals are most likely to apply them either toward offsetting charity care losses or financing modernization or expansion.[77] A compelling

private participation in the financing of hospital care to indigents has been a major point of contention with the American Hospital Association: "The passage of Public Law 89-97 underscored the fundamental weaknesses in health care financing. This governmental program assumed the burden for the payment of health care bills of a large segment of the population but explicitly renounced any obligation to share in the meeting of the total needs of our health care system, except as that system met the needs of the program beneficiaries. All contracting agencies, jointly and separately, must recognize the total community services obligations of the providers of service." AMERICAN HOSPITAL ASSOCIATION, STATEMENT ON THE FINANCIAL REQUIREMENTS OF HEALTH CARE INSTITUTIONS AND SERVICES iii (1969). Congressional commitment to the obligation of private nonprofit hospitals for the provision and, through their patients and charitable contributions, the financing of free and below-cost services to indigents was recently reaffirmed through the enactment of §1604(b)(1)(J)(ii) of the National Health Planning and Resources Development Act of 1974, *supra* note 60, which sets forth the obligation of recipients of construction and/or modernization funds to make a "reasonable volume" of services available to those unable to pay therefor.

[77] Revenue Ruling 69-545 offers the following example: "Hospital A is a 250-bed community hospital. . . . Patients who cannot meet the financial requirements for admission are ordinarily

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case can be made that much of the hospital construction now proposed is not in the public interest. In 1974, conservative estimates placed the number of excess, unnecessary acute care hospital beds in America at between 67,000 and 110,000.[78] Since the maintenance costs for each empty hospital bed average $20,000 per year, the cost to society of this excess hospital capacity amounted to approximately $2 billion that year.[79] In recognition of this waste, Congress recently enacted legislation providing for tighter controls on hospital expansion.[80] Thus, to the extent that Revenue Ruling

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referred to another hospital in the community which does serve indigent patients. The hospital usually ends each year with an excess of operating receipts over operating disbursements from its hospital operations. Excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research."

[78]In 1972 the federal Hill-Burton agency estimated that there were 110,000 excess acute care hospital beds in the United States. U.S. DHEW HEALTH RESOURCES ADMINISTRATION, HEALTH CARE FACILITIES SERVICES, GENERAL HOSPITALS AND OUTPATIENT FACILITIES, EXISTING AND NEEDED AS OF JAN. 1, 1971 (1972). The 67,000 estimate of excess beds is based on a private study assuming that an optimal nation-wide occupancy rate is 81 percent. See SATTLER & BENNETT, *supra* note 63.

[79]REGIONAL HEALTH PLANNING COUNCIL, NORTH CENTRAL TEXAS COUNCIL OF GOVERNMENT, THE FINANCIAL IMPACT OF HOSPITAL OVERBEDDING (June 1974).

[80]Section 1623(a)(4)(B) of the National Health Planning and Resources Development Act of 1974, *supra* note 60, conditions the receipt of resources development funds by a State upon its establishment and administration of a certificate of need program which will "provide that only those services, facilities, and organizations found to be needed shall be offered or developed in

[footnote continued]

69-545 diverts philanthropic funds from charity care to hospital expansion, it is arguably doing the nation a serious and costly disservice.

III.

REVENUE RULING 69-545 DOES NOT SET FORTH A SATISFACTORY MEANS BY WHICH HOSPITALS CAN MEET THEIR LEGAL OBLIGATION TO PERSONS UNABLE TO PAY.

A. Medicaid and Medicare Patients are not Persons Unable to Pay.

In requiring hospitals to accept beneficiaries of the Medicaid and Medicare programs, Revenue Ruling 69-545 does not thereby provide for persons unable to pay for hospital care. Medicare and Medicaid pay hospitals the full amount of costs actually incurred in connection with the provision of services to program beneficiaries.[81]

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the State." The intent of this requirement is, *inter alia*, to control expansion of bed capacity by private nonprofit hospitals. S. REP. NO. 1285, 93d Cong., 2d Sess., 4 U.S. Code Cong. & Admin. News 7878-79 (1974).

[81]See *Catholic Medical Center v. Rockefeller*, 305 F. Supp. 1256 (E.D. N.Y. 1969), vacated and remanded, 397 U.S. 820 (1970), order reentered, 305 F. Supp. 1268 (E.D. N.Y. 1970), aff'd *per curiam*, 430 F.2d 1297 (2d Cir. 1970), appeal dismissed, 400 U.S. 931 (1970).

See also 39 FED. REG. 31766 (1974), in which the Secretary of HEW notes that the federal Medicaid law requires full payment of all reasonable costs and states: "Concern has been expressed by representatives of the American Hospital Association that some States have in the past, in violation of their Title XIX State plans, failed to reimburse hospitals at the required reasonable cost level . . . The Secretary knows of no instance, however, in which such a violation has occurred without being promptly rectified with full reasonable cost reimbursement of all services

[footnote continued]

Rather than undermining the financial position of private, nonprofit hospitals, "reasonable cost" reimbursement under Medicare and Medicaid have greatly improved the economic position of these institutions.

Hence, this requirement is nothing more than a statement that exempt hospitals may not arbitrarily discriminate against certain classes of people who are able to pay the full cost of the service. Sound policy reasons support a rule that tax-exempt hospitals should not arbitrarily discriminate against particular groups of people who are fully able to pay, whether that discrimination is based on race, age or economic class. However, prohibiting arbitrary discrimination against particular classes of patients does not meet the statutory requirement that nonprofit hospitals must provide charity in order to be tax-exempt.

B. Emergency Room Care is Not a Satisfactory Means of Meeting the Needs of Persons Who Require Free and Below-Cost Hospital Care.

The requirement that a private, nonprofit hospital have an emergency room does not in itself fulfill the legal obligation to provide free services to persons unable to pay. Far more crucial to persons unable to pay is the extraordinary expense of inpatient hospital care, which is not available in the emergency room.

Furthermore, the meaning to be given to "emergency room service" is itself vague and ambiguous. The Court of Appeals, 506 F.2d 1278, 1289 seems to be referring to

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provided by hospitals. If there should in the future be any instance in which States fail to adhere to State plan requirements, affected hospitals are urged to so inform the appropriate Regional Commissioner of the Social and Rehabilitation Service."

the practice of providing outpatient services to poor persons in the emergency room when they do not have access to a private physician. The unmistakable trend, however, is for hospitals and other community facilities to set up clinics outside the emergency room to provide non-emergency outpatient care.[82] The legislative history of the Emergency Medical Services Systems Act, [42 U.S.C. §300d, *et seq.*] in acknowledging the extensive use of the emergency room for non-emergency outpatient services, contains the observation that,

> This increased community reliance on the services of the emergency room has overburdened its resources and has vastly compounded the difficulties of providing effective critical care to the emergency victim.[83]

Emergency room care is defined to mean only that care which a hospital chooses to provide in its emergency room.[84] Thus, it would appear that a hospital which improves the capacity of its emergency room to handle true emergencies thereby divests itself of any further obligation to provide outpatient services for persons unable to pay.

Nor is it necessarily advisable to require a hospital to operate an emergency room. Over 37% of the private nonprofit hospitals in this country do not have "basic

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[82]Jacobs, Gavett, and Wersinger, *Emergency Department Utilization in an Urban Community*, 216 AM. MEDICAL ASSN. J. 307 (1971); AMERICAN HOSPITAL ASSOCIATION, EMERGENCY SERVICES 53-54 (1972).

[83]S. REP. NO. 397, 93d Cong., 1st Sess., 2 U.S. Code Cong. & Admin. News 2548 (1973).

[84]AMERICAN HOSPITAL ASSOCIATION, EMERGENCY SERVICES viii (1972).

emergency services."[85] Federal policy has sought to coordinate emergency services in a particular area, and the Emergency Medical Services Systems Act (42 U.S.C. §300d) seeks effective utilization of available, personnel, facilities and equipment, [42 U.S.C. §300d-5(b)(4)(C)(vii)] while "avoiding expensive and unnecessary duplication of equipment and facilities and poor utilization of scarce staff and financial resources."

If "emergency room care" is intended to refer to the primary function of emergency rooms in providing acute emergency care arising out of trauma, accidents, and other serious, unpredicted events,[86] this function is considered a cost of doing business for any hospital, including for-profit concerns, and is not classified as charity care.[87] On the contrary, the hospital is free to

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[85]J. OF THE AM. HOSPITAL ASSN., Guide Issue, 484 (Aug. 1971).

[86]Torrens and Yedvab, *Variations Among Emergency Room Populations: A Comparison of Four Hospitals in New York City*, 8 MEDICAL CARE 60 (1970).

[87]Hospitals provide emergency services more to protect themselves from a lawsuit than to protect their tax-exempt status. Developing state court case law is following *Manlove v. Wilmington General Hospital*, 54 Del. 15 (1961) 174 A.2d 135 (1961) which held that a hospital operating an emergency room is holding itself out to the public as providing emergency services and therefore cannot refuse service to anyone. In some states, all hospitals have a statutory duty to render emergency services if they operate an emergency room. See ILLINOIS CODE, Chapt. 111 1/2, No. 86; CALIFORNIA HEALTH AND SAFETY CODE §1317. In order to qualify for funds under The Emergency Medical Services System Act (1973), 42 U.S.C. §300d *et seq.*, a hospital or service area would have to, "provide, without prior inquiry as to ability to pay, necessary emergency medical services to all patients requiring such services . . ." 42 U.S.C. §300d-5(b)(4)(C)(ix).

transfer the patient to another hospital after only the most cursory form of first-aid is provided.

IV.

THE FAR-REACHING CHANGES IN THE "CHARITABLE" STATUS OF PRIVATE, NONPROFIT HOSPITALS COULD BE EFFECTUATED, IF AT ALL, ONLY AFTER COMPLIANCE WITH THE ADMINISTRATIVE PROCEDURE ACT.

The American Public Health Association believes that Revenue Ruling 69-545 represents a drastic change in the previous law, eliminates important rights of the citizens whom Petitioners represent, has a substantial impact upon both the public and private sectors of the hospital industry, and is necessarily predicated upon assumptions of fact which are not within the particular expertise of the Respondent. Under settled principles, all of these reasons require that the Respondent comply with the rule making procedurees of the Administrative Procedure Act.[88] If the Respondent had complied with the procedures mandated by the Administrative Procedure Act, and had received a full range of relevant information, we believe that the policy change effectuated by Ruling 69-545 might never have been made.

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[88]See *Lewis-Mota v. Secretary of Labor*, 469 F.2d 478 (2d Cir. 1972); *Texaco v. Federal Power Comm'n*, 412 F.2d 740 (3d Cir. 1969). See also, *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402 (1971).

CONCLUSION

For the reasons set forth, this Court should reverse the judgment of the Court of Appeals and grant to plaintiffs such other and further relief as this Court deems proper.

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No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,
Petitioners,
vs.
WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *et al.*,
Respondents,

No. 74-1124

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *et al.*,
Petitioners,
vs.
EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,
Respondents.

ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR AMICUS CURIAE AMERICAN HOSPITAL ASSOCIATION

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In the Supreme Court of the United States

October Term, 1975

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,
Petitioners,

vs.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *et al.*,
Respondents,

No. 74-1124

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *et al.*,
Petitioners,

vs.

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,
Respondents.

ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR AMICUS CURIAE AMERICAN HOSPITAL ASSOCIATION

INTEREST OF THE AMICUS

This Brief is presented on behalf of the American Hospital Association (hereinafter "AHA") in opposition to the brief submitted on behalf of the Eastern Kentucky Welfare Rights Organization, et al.[1] The consents of the parties to the filing of this Brief have been filed with the Clerk of the Court.

AHA is an association whose membership includes more than 3,000 voluntary nonprofit hospitals. The interest of AHA in this case arises from the fact that these hospitals are the organizations whose charitable status forms the underlying issue in this case, and whose tax-exempt status is determined alternatively under the criteria of *Rev. Rul. 56-185*, 1956-1 CUM. BULL. 202 or the criteria of *Rev. Rul. 69-545*, 1969-2 CUM. BULL. 117.

Plaintiffs are seeking to have the criteria for exemption in *Rev. Rul. 69-545* declared invalid. However, AHA believes that that Ruling, upheld in the decision below, is a valid interpretation of the charitable provisions of section 501 (c) (3) of the Internal Revenue Code of 1954.[2]

QUESTION TO BE DISCUSSED

The substantive issue in this case is whether the criteria set forth in *Rev. Rul. 69-545* for qualification of nonprofit hospitals as tax-exempt organizations are consistent with section 501(c) (3). While AHA recognizes that there are also important procedural issues involved in this case, AHA will only discuss this question.

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[1] For convenience and consistency with the parties' briefs, hereinafter petitioners in 74-1110 will be called "plaintiffs" and petitioners in 74-1124 will be called "defendants." Plaintiffs' Brief is referred to as "Pl. Br."

[2] Hereinafter referred to as Code. All citations to Code, unless otherwise indicated, will be made to the Internal Revenue Code of 1954, as amended, 26 U.S.C. §1 et seq.

POSITION OF THE AMICUS

The voluntary nonprofit member hospitals of the AHA serve the health needs of communities throughout the United States. All of these hospitals are believed to be exempt from taxation under section 501(a) as charitable organizations described in section 501(c) (3) and as such recognize their obligation to provide services for the entire community, including its less fortunate members.

Plaintiffs' substantive position seems to be that *Rev. Rul. 69-545* is invalid because it is contrary to the charitable provisions of section 501(c) (3). The basis for this position appears to be that this Ruling allegedly eliminates any requirement of *Rev. Rul. 56-185* that nonprofit hospitals must provide "free" care for indigents as a condition to qualify for tax exempt status under section 501 (c) (3). While AHA shares plaintiffs' concern for adequate health care for the poor, it believes that the Ruling in question not only is a valid interpretation of the charitable provisions of section 501(c) (3), but also that it will, in fact, provide more effective access to hospital care for indigent persons than the standards supported by plaintiffs.

To the extent that *Rev. Rul. 56-185* predicates tax exemption of nonprofit hospitals primarily on relieving poverty, it is not consistent with the prevailing view of the law and its standards are not susceptible to objective and consistent application. On the other hand, the promotion of health rationale of *Rev. Rul. 69-545* more accurately reflects contemporary standards for tax exemption of such institutions and is therefore in accord with section 501(c) (3), the regulations and the case law, including the law of charitable trusts which forms the basis for Federal income tax exemption. Moreover, *Rev. Rul. 69-545* sets forth *alternative* criteria which are more susceptible

to objective and consistent application than the uncertain, inadministrable and superannuated free-care standards supported by plaintiffs.

SUMMARY OF ARGUMENT

The substantive issue in this case is simply one of statutory construction—whether *Rev. Rul. 69-545* is consistent with section 501(c)(3), or in other words, whether the Commissioner of Internal Revenue (hereinafter "Commissioner") was acting within the scope of his authority in issuing *Rev. Rul. 69-545*. Section 501(c)(3) provides tax exemption to organizations which are organized and operated exclusively for "religious, charitable, scientific, literary, educational purposes, or for the prevention of cruelty to children or animals." Under section 170, contributions to such organizations are also deductible in computing taxable income.

In 1956 under Treasury regulations then in effect, the Commissioner had issued *Rev. Rul. 56-185* which required, as a criterion for tax exemption under section 501(c)(3), that a voluntary nonprofit hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered." In 1969 *Rev. Rul. 69-545* was issued to provide alternative criteria for determining whether voluntary non-profit hospitals are organized and operated for exempt purposes and to modify the free care criterion of *Rev. Rul. 56-185*.

In issuing *Rev. Rul. 69-545*, the Commissioner recognized that in accordance with the Treasury regulations which had been revised and expanded in 1959, the term "charitable" is used in section 501(c)(3) in its generally accepted legal sense under the law of charity and charitable trusts and is not restricted to organizations relieving

poverty through the rendition of free or below cost care. The Ruling is based upon the established legal doctrine that the promotion of health for the benefit of the community is, in the absence of private benefit or profit, a charitable purpose within the meaning of section 501(c)(3). Because the criteria set forth in *Rev. Rul. 69-545* constitute an interpretation of "charitable" which is consistent with its generally accepted legal sense, the issuance of that Ruling was within the scope of the Commissioner's authority, and the decision of the Court of Appeals below should be upheld.

Central to the law of charity and charitable trusts, and thus to section 501(c)(3), is the concept that charitable purposes must be broadly defined to include all purposes which promote man's well-being and which are beneficial to the community. One such purpose which has been recognized as charitable under English and American law is the relief of the distress of sick and aged persons, or in other words, the promotion of health. In the eyes of the law, because the act of caring for the sick or aged is, in and of itself, an act of compassion or "charity," nonprofit organizations engaged in ministering to the needs of this charitable class are not also required to render assistance to the poor in order to be classified as charitable. For this reason, the law has recognized that a nonprofit hospital, whose assets are devoted to the care of the sick and whose operations are free of any private benefit or profit to its founders or those in control, is a charitable organization.

Plaintiffs have attempted to refute these established legal principles by asserting that tax exemption of nonprofit hospitals must be based exclusively on their lessening of burdens of government through the provision of free care to the poor. Such assertion is inaccurate and does not reflect the prevailing legal view. Lessening of burdens of government is but one of two rationale underly-

ing the tax exemption of charitable institutions. The prevailing and more logical view is that governments grant tax exemption to encourage humanitarian and other socially useful functions by the private sector.

The criteria for exemption of nonprofit hospitals under *Rev. Rul. 69-545* is, in fact, supported under both rationale. The relief of the distress of the sick is certainly a humanitarian and socially useful activity. At the same time, voluntary nonprofit hospitals lessen the burdens of government because without them government would be forced to assume the entire responsibility for delivering hospital care.

Because the law of charity is centered around this concept of community benefit, it is in constant motion and is ever changing to meet the shifting needs and demands of society, lest it become stagnant. *Rev. Rul. 69-545* does no more than reflect certain basic changes in the law of charity engendered by the law's response to historic changes in the nature, function, and financing of the hospital as an institution in American society.

Our early "charitable" hospitals grew out of the almshouses and pest houses of the 18th Century. While they provided a refuge for the poor and unwanted, their unsanitary and primitive conditions discouraged their widespread uses by all but the less fortunate members of society. The early legal definition of a charitable hospital reflected these conditions by characterizing it as an institution which was (1) primarily concerned with indigents, (2) precluded from serving any substantial number of paying patients, (3) required to provide free care, and (4) funded by charitable contributions to pay for such care.

During the 19th and into the 20th Century, hospital conditions began to improve and hospitals began to evolve into centralized health facilities for the entire community.

Pay patients began to make substantial use of these facilities for the first time, and the payments hospitals received for their care, which generally exceeded the cost of such care, were added to charitable endowments to underwrite free care for the poor. The law of charity reflected these changes by recognizing that a charitable hospital could serve "rich and poor alike," thus permitting hospitals to treat pay patients without risking their charitable status.

By the last half of the 20th Century, other important changes had occurred. Most important was the shift in the funding of hospital care to reimbursement by both private and governmental third parties. In the governmental sector there was a rapid growth in social welfare legislation to provide government funding of health care for the poor through reimbursement to providers. This resulted in a decline in the percentage of patients who lacked some form of private or public coverage and therefore resulted in fewer persons who required free care. At the same time, the ability of the charitable hospital to underwrite the cost of free care for those without coverage was also declining. The free care test for charitable hospitals, prevalent under prior law, fell into discredit as anachronistic and inadministrable in light of such recent social and economic changes, and the charitable status of nonprofit hospitals was recognized despite the absence of free care.

This also reflects the dedication of the Federal government to a policy of improving the quality of health care for all Americans. However, the implementation of this objective is encompassed in a Federal policy directed toward providing reimbursement of health services for persons unable to pay. Programs such as Medicare and Medicaid, and proposals for national health insurance, are all directed toward, and examples of, the Federal reimbursement policy. Federal policy does not, as plaintiffs contend, require hospitals to provide free, unreimbursed care. Such

a policy could only perpetuate the inequities resulting from continued dependence of the poor on the dole.

The approach under *Rev. Rul. 69-545* to exemption of nonprofit hospitals under section 501(c)(3) is also consistent with Federal case law. This body of law has never addressed itself directly to the question before the Court, namely, whether the delivery of free care is an absolute requirement for a tax-exempt hospital. Rather it has concerned itself with the question of whether a particular institution is operating in the public interest or in furtherance of private interests. In providing criteria for distinguishing the operations of a nonprofit hospital in the public interest from those furthering private interests, *Rev. Rul. 69-545* is consistent with the thrust of Federal case law.

Rev. Rul. 69-545 is also consistent with the legislative history of section 501(c)(3) which indicates an intent to cover organizations operating for humanitarian purposes, such as relief of the distress of the sick and aged. The legislative "inaction" cited by plaintiffs does not indicate a contrary policy and does not support plaintiffs' attempt to restrict the charitable exemption under section 501(c)(3) to relief of the poor. Such inaction, to the extent it may be relevant to statutory construction, more accurately indicates a Congressional desire to leave the administration of the charitable provisions of the Code to the Commissioner.

Plaintiffs also discount the obligation of the Commissioner to revise the criteria of rulings which antedate the promulgation of Treas. Reg. §1.501(c)(3)-1(d)(2) and which no longer comport with the expanded definition of the term "charitable" contained therein. *Rev. Rul. 56-185*, published under earlier, more restrictive regulations and requiring relief of poverty as a condition to exemption, was one such ruling.

Furthermore, modification of *Rev. Rul. 56-185* was required because of the serious administrative inadequacies resulting from its test of free care. The practical effect of this test was to substitute the judgment of an examining agent over that of hospital administrators, trustees and local health councils with respect to determining a hospital's priorities for utilizing any so-called surplus funds between free care for the poor and other programs beneficial to the community.

In issuing alternate criteria for exemption in *Rev. Rul. 69-545*, the Commissioner did not, as plaintiffs contend, ignore the plight of the poor upon which the earlier ruling had focused. Instead, *Rev. Rul. 69-545* makes a contribution toward improving the access of the poor to hospital care which is at least, if not more, effective than the ambiguous "extent of financial ability" standard of free care in *Rev. Rul. 56-185*. Hospitals seeking to qualify under *Rev. Rul. 69-545* must establish that they maintain an emergency room which is available to all, regardless of ability to pay, and adhere to a policy of not refusing admission to Medicare and Medicaid patients for inpatient care. These conditions, not found under prior rulings, insure that an exempt hospital will operate for the benefit of the entire community, including the poor.

Finally it must be noted that the one question underlying this litigation for which no adequate answer has been offered is—where is the money to come from to pay for the 40 million persons alleged by plaintiffs to be in need of free hospital care? Without a satisfactory answer to this question, a reversal of the lower court decision would be tantamount to a judicially enacted program of national health insurance *without funding*. The traditional sources which enabled our voluntary nonprofit hospitals to serve the indigent without charge—philanthropy, patient payments of rates in excess of cost, and surpluses generated

from hospital operations—are neither adequate, and in many cases no longer available.

First, philanthropy, although still an important source of capital, is no longer the significant source of underwriting free care. The simple fact is that contributors generally give to the hospital of their choice out of a desire to improve its facilities and its ability to deliver the highest quality of care to the community which benefit the rich and poor alike, rather than for the expansion of services exclusively for the poor. A reversal of the lower court decision will discourage, rather than encourage, the already dwindling funds available through philanthropy.

Second, the percentage of hospital expenditures reimbursed on the basis of cost (from which the cost of indigent care must be excluded) was 72.8% in 1972, and has been steadily increasing. This leaves the modern hospital with a steadily declining base for charging fees in excess of cost in order to underwrite the cost of free care; and the self-pay and commercially insured patients that would have to bear these costs are already painfully overburdened.

Third, in the case of those hospitals that manage to generate an illusory appearance of a surplus, the replacement of facilities and equipment in the current inflationary period can easily change their cash flow position to the red. If the same hospitals were treated as non-exempt, the deductions taken for depreciation under proper accounting methods would rarely keep up with increases in the cost of replacement.

Fourth, even in those cases where a hospital may be in a favorable cash position, it nevertheless will still have other priorities to be considered in determining how it can best serve the community. The devotion of any surplus by a hospital "to the extent of its financial ability" exclusively to indigent care can be to the detriment of its

ability to provide the overall community with other needed services, such as medical education, training and research, the purchase of new equipment developed under modern technology, the implementation of new medical techniques, and the establishment of other facilities needed by the community, such as those for mental health and drug abuse.

Thus, the picture painted by plaintiffs of our voluntary, nonprofit hospitals as institutions unconcerned with the plight of the poor is unfounded. Most of our private nonprofit hospitals, particularly those in communities lacking any public facilities, do admit and treat persons unable to pay. To the extent that there may be hospitals that do not provide the amount of free care desired by plaintiffs, it is not out of a lack of compassion, but because of economic necessity and a concern for the greater good of the rest of the community which must also be served by these institutions.

Pushed to its logical conclusion, plaintiffs' position would require nonprofit hospitals to underwrite the equivalent of a program of national health insurance. However essential Federal income tax exemption may be, it is simply not the equivalent of "just compensation" within the purview of the Fifth Amendment. U.S. CONST. amend. V. A judicial adoption of plaintiffs' position could effectively repeal the application of section 501(c)(3) to nonprofit hospitals.

ARGUMENT

I. REV. RUL. 69-545 IS CONSISTENT WITH THE CHARITABLE PROVISIONS OF SECTION 501(c)(3) OF THE INTERNAL REVENUE CODE.

Rev. Rul. 69-545 provides that nonprofit hospitals which satisfy certain specified criteria shall be considered "charitable" and thus tax-exempt under section 501(c)(3). The authority for the promulgation of all revenue rulings derives from section 7805 of the Code.[3] By virtue of that section, the Commissioner may lawfully issue any revenue ruling interpreting a provision of the Code,[4] or reflecting a change or modification of existing rulings,[5] provided such interpretations or modifications are consistent with and supported by law. *Rev. Rul. 69-545* therefore must be held lawful and valid, and thus within the scope of the Commissioner's authority under section 7805, if it is consistent with the legal meaning of the term "charitable" as used in section 501(c)(3).

A. The Term "Charitable" in Section 501(c)(3) Must Be Interpreted in Its Generally Accepted Legal Sense.

Section 501(c)(3) of the Internal Revenue Code of 1954 exempts from Federal income taxation organizations

> "operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures

[3] Under section 7805 the Secretary or his delegate (the Commissioner) is authorized to "prescribe all needful rules and regulations for the enforcement of this title, including all rules and regulations as may be necessary by reason of any alteration of law in relation to internal revenue."

[4] *See* Fribourg Navigation Co. v. Comm'r, 383 U.S. 272 (1966).

[5] *See* Dixon v. United States, 381 U.S. 71, 75 (1965).

> to the benefit of any private shareholder or individual. . . ."

It is well established that the term "charitable" is used in section 501(c)(3) in its generally accepted legal sense, is not limited by the separate enumeration of other tax exempt purposes in that section and must be construed within the broad outlines of "charity" as developed by judicial decisions. Treas. Reg. §1.501(c)(3)-1(d)(2) (1959).[6] This Regulation reflects the long-standing recognition of the fact that the interpretation of the term "charitable" for purposes of the charity provisions of the Code is governed by the general law of charities and charitable trusts.[7] Both the Internal Revenue Service (hereinafter "IRS") and the courts have exhibited a continuing commitment to this rule.[8] A recent IRS expression of this

[6] The Regulation states, in part:

> "The term 'charitable' is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decisions."

Treas. Reg. §1.501(c)(3)-1(d)(2) was promulgated in its present form in 1959 as T.D. 6391, 24 Fed. Reg. 5217 (1959) and has remained in effect without change through numerous amendments to the exempt organization provisions of the Code, particularly the extensive enactments relating to charities in the Tax Reform Act of 1969, Pub. L. No. 91-172, 83 Stat. 487, and thus may be deemed to have the tacit approval of Congress.

[7] *See, e.g.*, Pennsylvania Co. for Ins. v. Helvering, 66 F.2d 284, 286 (D.C. Cir. 1933); Girard Trust Co. v. Comm'r, 122 F.2d 108 (3d Cir. 1941); Samuel Friedland Found. v. United States, 144 F. Supp. 74, 81-82 (D. N.J. 1956).

[8] For example, in holding a bequest for the erection of a community auditorium to be charitable and thus deductible under section 403(a)(3) of the Revenue Act of 1918, Sol. Op. 159, III-1 CUM. BULL. 480 (1924), states:

> "It becomes necessary to determine just what was contemplated by Congress in the use of the word 'charitable'. There being no statutory definition of the word, it must be construed in accordance with its well understood common law

(Footnote continued on following page)

principle is found in *Rev. Rul. 67-325*, 1967-2 CUM. BULL. 113:

> "The favored treatment of charitable organizations for Federal tax purposes in the income, estate and gift tax legislation enacted in the current century has not provided a comprehensive definition of charitable purposes in the various statutory provisions that have been enacted. *It is clear for this and other reasons that those statutory provisions* do not reflect any novel or specialized tax concept of charitable purposes, and that the income, estate, and gift tax provisions of the Code here in question *should be interpreted as favoring only those purposes which are recognized as charitable in the generally accepted legal sense.*" (Emphasis supplied.)

The strongest judicial recognition of the importance of the general law of charities and charitable trusts in interpreting the charitable exemption is stated in *Green v. Connally*, 330 F. Supp. 1150, 1157 (D. D.C. 1971), *aff'd per curiam sub. nom. Coit v. Green*, 404 U.S. 997 (1971):

> "[C]learly, the term 'charitable' is used 'in its generally accepted legal sense,' Treas. Reg. §1.501(c)(3)-1(d)(2), and not in a street or popular sense (such as, e.g., benevolence to the poor and suffering) . . . Thus 'strong analogy' can be derived from the general common law of charitable trusts, at least for close interpretative questions."[9]

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meaning. In *Rice v. Minnesota & Northwestern Railroad Company* (1 Black, 358) the Supreme Court of the United States said: 'In the construction of the laws of Congress the rules of common law furnish the true guide.'"

See also Swearingen v. United States, 161 U.S. 446 (1895); United States v. Wong Kim Ark., 169 U.S. 649 (1898); 2A D. SANDS, STATUTES AND STATUTORY CONSTRUCTION §50.04 (4th ed. 1973).

[9] The Court of Appeals for the District of Columbia, in interpreting the phrase "organized and operated exclusively for

(Footnote continued on following page)

B. Rev. Rul. 69-545 Is Based Upon the Established Legal Doctrine That Promotion of Health for the Benefit of the Community Is, in the Absence of Private Benefit, a Charitable Purpose Within the Meaning of Section 501(c)(3).

Prior to the publication of *Rev. Rul. 69-545*, the criteria for tax exemption of nonprofit hospitals were generally set forth in *Rev. Rul. 56-185*. Although this Ruling required consideration of various factors in order to determine a hospital's charitable status, particular emphasis had been placed on the requirement that "[i]t must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." The satisfaction of this requirement was generally interpreted to require that a hospital must provide some undefined percentage of services to indigent patients without charge or at reduced rates.

Rev. Rul. 69-545 was issued to provide alternative standards for determining the qualification of nonprofit hospitals for tax exemption under section 501(c)(3).[10]

(Continued from previous page)

religious, charitable, scientific, literary, or educational purposes" for purposes of section 1(b)(7) of the District of Columbia Unemployment Compensation Act, found a Congressional intent "to apply the exemption to those organizations commonly designated charitable in the law of trusts. Consequently, we may properly draw analogy from the trust cases." Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337, 339 (D.C. Cir.), *cert. denied*, 317 U.S. 693 (1942).

[10] As stated by the Court of Appeals below:

> "It is important to note also that Revenue Ruling 69-545 rather than over-ruling Revenue Ruling 56-185 simply provides an alternative method whereby a nonprofit hospital can qualify as a tax exempt charitable organization." Pl. Br. for Certiorari App. C. at 27a.

The rationale of the Ruling, as set forth in its text,[11] is that the promotion of health is a charitable purpose in the generally accepted legal sense. A nonprofit hospital, which is free of private benefit and which is engaged in the promotion of health in a manner beneficial to the community, is therefore a charitable organization within the meaning of section 501(c) (3). As evidence that a nonprofit hospital is serving a broad enough class to benefit the community, *Rev. Rul. 69-545* requires an exempt hospital to (a) operate an emergency room open to all persons and (b) provide hospital care for all those persons in the community able to pay the cost thereof, directly or through third party reimbursement.

The Ruling also provides that further evidence of benefit to the community can be established by other factors, such as the use of surplus funds to improve the quality of patient care, expansion of facilities and advancement of medical training, education and research programs; broad public control; and maintenance of an open medical staff.[12]

[11] Rev. Rul. 69-545, 1969-2 CUM. BULL. 117, 118 states:

"In the general law of charity, the promotion of health is considered to be a charitable purpose. *Restatement (Second), Trusts*, sec. 368 and sec. 372; IV *Scott on Trusts* (3d ed. 1967), sec. 368 and sec. 372. A nonprofit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose. . . .

. . . .

"The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community. *Restatement (Second), Trusts*, sec. 368, comment (b) and sec. 372, comments (b) and (c); IV *Scott on Trusts* (3d ed. 1967), sec. 368 and sec. 372.2."

[12] "These factors indicate that the use and control of Hospital *A* are for the benefit of the public and that no part of the income of the organization is inuring to the benefit of any private individual nor is any private interest being served." *Id.*

Finally, *Rev. Rul. 69-545* removes as an indispensible criterion to qualification under section 501(c)(3) the requirement of rendering care for patients without charge or at rates below cost.

Thus, as stated in *Rev. Rul. 69-545*, the basis for the alternative standards set forth therein for tax exemption of nonprofit hospitals is that promotion of health in a manner which is beneficial to the community and free of any private benefit or profit is a charitable purpose. If this fundamental proposition is consistent with the general law of charities and charitable trusts, and thus the charitable provisions of section 501(c)(3), the decision of the Court of Appeals below must be affirmed.

C. The Promotion of Health Is a Charitable Purpose.

Any discussion of charitable purposes must begin with the fundamental principle that "[a] design to achieve objects beneficial to the community is common to all charitable purposes." *In re Tollinger's Est.*, 349 Pa. 393, 397, 37 A.2d 500, 502 (1944); *In re United Presbyterian Homes*, 428 Pa. 145, 148, 236 A.2d 776, 779 (1968).[13] For this reason, the term "charitable" has traditionally been defined broadly enough to encompass all of those activities which promote the well-being of man.[14]

Since the enactment of the Statute of Elizabeth (aka the Statute of Charitable Uses), Stat. 43 Eliz. 1, c.4 (1601),

[13] In *Green v. Connally*, 330 F. Supp. 1150, 1158 (D. D.C. 1971) the court said:

"Underlying the law of charitable trusts is the conception, both in definition and in requirement, that a charitable trust is one formed to serve the general welfare and be beneficial to the community."

See also A. SCOTT, THE LAW OF TRUSTS §374 (3d ed. 1967); G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES §363 (2d ed. 1964).

[14] In *Ould v. Washington Hosp.*, 95 U.S. 303, 311 (1877) the Court said:

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certain specific purposes have come to be widely regarded in the law as charitable. Nevertheless, because of the difficulty of enumerating every purpose in the ever expanding catalogue of charitable purposes, great weight has been given to Lord Macnaghten's definition in *Commissioners v. Pemsel*, [1891] A.C. 531, 583, 3 Tax Cas. 53, 96, which enumerates three basic charitable purposes and a fourth charitable category of other purposes beneficial to the community.

Referring to this classic statement, Mr. Justice White, concurring in *Evans v. Newton*, 382 U.S. 296, 307-08 (1966), observed:

> "Lord Macnaghten established a classification of charitable trusts that, with some modifications, has since prevailed: ' "Charity" ' in its legal sense comprises four principal divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the preceding heads."[15]

As far back as the Statute of Elizabeth's classification of the "relief of aged, impotent, and poor people" as a charitable purpose, it has also been recognized that, as a matter of law, the relief of the suffering and distress of sick and

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> "A charitable use, where neither law nor public policy forbids, may be applied to almost any thing that tends to promote the well-doing and well-being of social man."

A similar broad treatment is applied to the nature of charitable purposes in RESTATEMENT (SECOND) OF TRUSTS §368 and *Comment (b)* (1959):

> "A purpose is charitable if its accomplishment is of such social value to the community as to justify permitting the property to be devoted to the purpose in perpetuity."

[15] *See also* Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337, 339 (D.C. CIR. 1942); RESTATEMENT (SECOND) OF TRUSTS §368 (1959).

aged persons is a charitable purpose.[16]

Although relief of the distress of the sick and aged has often been subsumed under Lord Macnaghten's fourth category of purposes beneficial to the community, it has more frequently been spun off from this category and separately treated as a fifth heading of charitable purposes in English and American law.[17] It is now "well settled that the promotion of health is a charitable purpose." A. SCOTT, THE LAW OF TRUSTS §368, at 2853 (3d ed. 1967); *id.* §372, at 2893 and cases cited at 2894-97; G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES §374, at 107 (2d ed. 1964).[18]

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[16] Another classic and widely cited definition of charity is Justice Gray's in *Jackson v. Phillips*, 96 Mass. (14 Allen) 539,556 (1867):

> "A charity is a gift to be applied consistently with existing laws, for the benefit of an indefinite number of persons, either by bringing their minds or hearts under the influence of education or religion, *by relieving their bodies from disease, suffering or constraint*, by assisting them to establish themselves in life, or by erecting or maintaining public buildings or works, or otherwise lessening the burdens of Government." (Emphasis supplied.)

[17] "[T]he relief of distress, that is . . . 'the relief of any form of necessity, destitution or helplessness which excites the compassion or sympathy of men', could with advantage be moved out of the fourth head. It is charitable not because of the immediate benefit to the public but for reasons of human sympathy *akin to those which make relief of poverty a charitable object* . . . The relief of distress could, if desired, be treated as a separate fifth head of charity or it might well be combined with relief of poverty, which is in truth one among many forms of distress." Brunyate, *The Legal Definition of Charity*, 61 L. Q. REV. 268, 281 (1945) (emphasis supplied).

[18] "[T]he promotion of health is a valid charitable purpose in all American jurisdictions." E. FISCH, D. FREED AND E. SCHACHTER, CHARITIES AND CHARITABLE FOUNDATIONS §322, at 275 (1974); *see also id.* §322, at 275 n.18.

RESTATEMENT (SECOND) OF TRUSTS §368 (1959):

"Charitable purposes include

"(a) the relief of poverty;

"(b) the advancement of education;

(Footnote continued on following page)

The true significance of the treatment of promotion of health as a separate charitable purpose in the law of charity is that it forms an independent basis for the underlying principle of *Rev. Rul. 69-545* that a nonprofit health organization, free of the taint of private benefit or profit, qualifies as a charitable organization without regard to providing free care for the poor.[19]

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"(c) the advancement of religion;
"(d) *the promotion of health;*
"(e) governmental or municipal purposes;
"(f) other purposes the accomplishment of which is beneficial to the community."

(Emphasis supplied.)

"[T]he care of the sick and the suffering is generally recognized as a charitable purpose." Duncan v. Steeper, 17 Wis. 2d 226, 116 N.W.2d 154, 158 (1962); *see* Sacks, *The Role of Philanthropy: An Institutional View*, 46 VA. L. REV. 516, 518 (1960).

[19] In recognition of the legal principle that the promotion of health is a charitable purpose, the IRS has issued a series of revenue ruling recognizing the tax-exempt status of organizations under section 501(c)(3) that are engaged in performing various functions relieving the distress of the sick and aged. If the lower court decision is reversed, some of the organizations whose exempt status would have to be reconsidered by the IRS, and perhaps denied. *See, e.g.*, Rev. Rul. 70-590, 1970-2 CUM. BULL. 116 (operating a clinic to aid drug victims); Rul. 68-73, 1968-1 CUM. BULL. 251 (organization ministering to the nonmedical needs of patients in a proprietary hospital); Rev. Rul. 55-656, 1955-2 CUM. BULL. 262 (a community supported nurse's registry); Rev. Rul. 66-323, 1966-2 CUM. BULL. 216 (blood bank); Rev. Rul. 69-525, 1969-2 CUM. BULL. 115 (organization conducting research in heart disease); Rev. Rul. 65-298, 1965-2 CUM. BULL. 163 (organization carrying on research on diseases of the human body); Rev. Rul. 73-569, 1973-2 CUM. BULL. 178 (an organization providing free abortion counseling); Rev. Rul. 69-174, 1969-1 CUM. BULL. 149 (organization providing free rescue and emergency services); Rev. Rul. 72-209, 1972-1 CUM. BULL. 148 (organization providing home health care); Rev. Rul. 73-313, 1973-2 CUM. BULL. 174 (organization formed to attract a physician to an isolated rural community); Rev. Rul. 72-124, 1972-1 CUM. BULL. 145 (homes for the aged); Rev. Rul. 75-198, 1975-22 INT. REV. BULL. 9 (service center for senior citizens); Rev. Rul. 75-197, 1975-22 INT. REV. BULL. 8 (organization operating a medical retrieval system for transplanting body organs).

D. The Relief of Poverty Is Not a Necessary Ingredient for Charitable Exemption.

Although the gravamen of the substantive dispute between the parties is whether the relief of poverty is a necessary ingredient of charitable purposes, this issue has long been settled.[20] The promotion of health is a charitable purpose because the alleviation of the suffering and distress of the sick and aged is, per se, a purpose beneficial to the community. Therefore, the relief of poverty is not necessary for this type of charity.[21]

The principle that charity is not limited to the relief of poverty was part of the common law during the period of the enactment of the first charitable exemption in the 1909 Act. Act of Aug. 5, 1909, ch. 6, §38, 36 Stat. 11, 113.[22] One widely quoted expression of this long-standing principle is that:

> "Since the enactment of the Statute of Charitable Uses during the reign of Elizabeth, aid to the aged and in-

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[20] "Although the relief of the poor, or a benefit to them is, in the popular sense, a necessary ingredient in charity, this is not so in view of the law." Paschal v. Acklin, 27 Tex. 173, 199 (1863).

[21] The courts have not limited their compassion to the poor, but also include as objects of charity other classes of distressed persons, such as the sick and aged. Although relief of poverty is a necessary ingredient for charities engaged exclusively in alleviating the needs of the poor, the same is not true of charities relieving other forms of distress. This principle was restated by Professor Bogert as follows:

> "A trust to furnish the necessities of life to persons who are financially able to provide for themselves is not charity of the type under consideration. There is no social benefit in relieving members of the public from the burden of supporting themselves or in providing luxuries for them. If the group possesses certain disabilities such as age, sickness or physical handicaps, a trust to furnish benefits to its members may qualify as a charity of another type, regardless of the financial status of its personnel." G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES §373, at 105 (2d. ed. 1964) (footnotes omitted).

[22] H. BLACK, A TREATISE ON THE LAW OF INCOME TAXATION 404 (2d ed. 1915):

(Footnote continued on following page)

> firm has been recognized as charitable . . . . Relief of poverty is not a condition of charitable assistance. If the benefit conferred has a sufficiently widespread social value, a charitable purpose exists. Restat. Trusts, Sec. 368, 374. *People v. Cogswell,* 113 Cal. 129, 45 P. 270, 35 L.R.A. 269; *Collier v. Lindley,* 203 Cal. 641, 266 P. 526; 16 Cal. L. Rev. 478." *In re Henderson's Est.*, 17 Cal. 2d 853, 112 P.2d 605, 607 (1941).[23]

Similarly, Professor Scott has observed that "[a] trust for the promotion of health, however, is none the less charitable, although the benefits are not limited to the poor."[24]

The recognition in American law that charity is not limited to the relief of poverty has developed from the interpretation of the charitable purposes enumerated in the Statute of Elizabeth,[25] the first of which is "the relief of aged, impotent, and poor people."[26] English jurists were confronted with a question similar to that raised by plaintiffs, namely, "whether age per se or impotence [i.e., sickness] per se without any element of poverty can be re-

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"[I]t is the general rule in the construction of exemptions from taxation that the word 'charity' is not to be restricted to the relief of the sick or poor, but extends to any form of philanthropic endeavor or public benevolence."

See also 14 C.J.S., *Charities* §12, at 439 (1939); Gerke v. Purcell, 25 Ohio St. 229 (1874).

[23] *Accord,* Commun. Mem'l Hosp. v. City of Moberly, 422 S.W.2d 290 (Mo. 1967); *In re* Rust's Est., 168 Wash. 344, 12 P.2d 396 (1932).

[24] A. Scott, The Law of Trusts §372, at 2895 (3d ed. 1967); *see also* Green v. Connally, 330 F. Supp. 1150, 1157 (D. D.C. 1971).

[25] Referring to American exemption statutes, Professor Zollmann states:

"It can admit of no doubt that the words 'charitable purposes' must be construed according to the standards set by the statute of Elizabeth and its interpretations." C. Zollmann, American Law of Charities 470 (1924); *see also* IV A. Scott, The Law of Trusts §348.3, at 2787.

[26] The term "impotent," as used in the Preamble of the Statute of Elizabeth, has been interpreted to mean sick persons. *Charitable Purposes,* 106 Sol. J. 969 (1969).

garded as good charitable objects."[27] In dispute was whether the phrase "relief of aged, impotent and poor people" should be read in the *disjunctive,* permitting charitable trusts to operate for the benefit of sick or aged people without reference to their financial condition, or in the *conjunctive,* thereby limiting charitable trusts to those operating for the benefit of the sick poor or the aged poor.[28]

The conclusion reached under English law was that "[t]he words 'aged, impotent and poor' should be read disjunctively."[29] For example, in 1954, Chancery held a bequest to blind children to be charitable, although there was no requirement of poverty, because the word "impotent," as used in the Preamble to the Statute of Elizabeth should be read disjunctively. *In re Lewis* (1954), 3 All E. R. 257.[30]

The disjunctive reading of the phrase "relief of aged, impotent and poor people" is now generally accepted as the

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[27] Atiyah, *Public Benefit of Charities,* 21 Mod. L. Rev. 138 (1958).

[28] A similar issue is raised in Pl. Br. at 17 n.12 with respect to Treas. Reg. §1.501(c)(3)-1(d)(2) which defines charity to include "Relief of the poor *and* distressed or of the underprivileged." (Emphasis supplied.)

[29] *In re* Glyn, [1950] 2 All E.R. 1150. *Accord, In re* Wall, [1889] 42 Ch. 510; *In re* Lucas, [1922] 2 Ch. D. 52; *In re* Bradbury, [1951] 1 T.L.R. 130 (Ch. D.); *In re* Robinson, [1951] Ch. 198; *see also In re* Roadley, [1930] 1 Ch.D. 524, 527: "A trust to provide out of the income for the expenses and maintenance of patients in a hospital is a trust for the relief of impotent people and therefore, in my judgment, a good charitable trust."

[30] Commenting on *In re Lewis,* one authority noted:

"This decision thus takes a further step in establishing that there are three separate types of charity under this head: (1) Trusts for the relief of poverty, (2) Trusts for the relief of the aged, and (3) Trusts for the relief of the impotent." Atiyah, *The Aged, Impotent and Poor,* 18 Mod. L. Rev. 76 (1955).

Accord, In re Estlin, 72 L.J. (Ch.D.) 687; *In re* Chaplin, [1932] 1 Ch.D. 115; *In re* James, [1932] 2 Ch. 25; *In re* Frasure, [1883] 22 Ch.D. 827; *In re* Elliott, [1910] 102 L.T.R. (n.s.) 528.

law of England.[31] Even the prestigous Nathan report, in reviewing the current status of the Law of Charity in England states:

> "One or two doubts were expressed. It was suggested, for example, that it was not wholly clear that the relief of sickness or of the infirmities of aged is a charitable object unless the conditions requiring relief is accompanied by poverty. *We believe these doubts to be unfounded.*" COMMITTEE ON LAW AND PRACTICE, REPORT RELATING TO CHARITABLE TRUSTS CMD. NO. 8710, at 33 (1952) (emphasis supplied).

Similar doubts have been expressed in American law, but have been dismissed either as a too narrow and restricted a view of charity[32] or simply as a mistaken view.[33] For example, in referring to the argument that a nonprofit home for aged was required to extend free services to at least some of its residents, the Supreme Court of Wisconsin stated:

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[31] *E.g.*, 5 HALSBURY'S LAWS OF ENGLAND §514 (4th ed. 1974); "The relief of 'aged, impotent and poor people' is charitable and the words are to be read disjunctively, so that the relief of aged people who are not also poor comes within them, and the relief of impotence, without any element of poverty is a charitable purpose."

Accord, In re Hiller, [1944] 1 All E.R. 480; Brunyate, *The Legal Definition of Charity*, 61 L. Q. Rev. 268 (1945).

[32] "Counsel for the Board insist that, in order to be classified as a charitable corporation, it is necessary that appellant show that its principal objectives are to provide for the poor, the sick, and the needy, but we think this is too narrow and restricted a formula." Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337, 339 (D.C. Cir. 1942).

[33] Duncan v. Steeper, 17 Wis. 2d 226, 116 N.W.2d 154, 158 (1962):

> "It is apparent that respondents harbor the *mistaken view* that an institution cannot be a charitable hospital unless it extends direct charity to at least some of its patients in the form of free service, or charges less than the cost of its services. This view was eloquently refuted by the Massachusetts court in the recent case of Barrett v. Brooks

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> "This is a 'mistaken view' whether applied to benevolent retired homes for the aged or to charitable hospitals. If the legislature had intended that a benevolent association must provide free admission or free services to all or some of the residents in its retirement home, it is to be expected that it would have so provided." *Milwaukee Protestant Home v. City of Milwaukee*, 41 Wis. 2d 284, 164 N.W.2d 289, 297 (1969) (footnote omitted).

Thus, the law of charity and charitable trusts does not support plaintiffs' assertion that "[s]ervice to persons unable to pay is the *sine qua non* for charitable hospitals."[34] Rather, the law is that the relief of poverty is not a required condition for charitable status of nonprofit hospitals.

E. A Nonprofit Hospital, Free of the Taint of Private Benefit or Profit, Is Charitable.

Since the promotion of health is a charitable purpose, and relief of the poor is not requisite to charitable status, numerous legal authorities have concluded that "[h]ospitals operated as nonprofit institutions are universally classed as charitable institutions. 15 AM. JUR. 2d, *Charities*, s. 79, p. 85, s. 148, p. 156; 14 C.J.S. *Charities* §2 e, p. 422; §16, p. 448; 84 C.J.S. *Taxation* §297, p. 617." *Evangelical Lutheran Good Samaritan Soc. v. County of Gage*,

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Hospital, Inc., [338 Mass. 754, 759, 157 N.E. 2d 638, 641 (1959)]:

> 'The defendant's charter does not contain any such word as "indigent." That is not necessary. "Charity in the legal sense 'is not confined to mere almsgiving or the relief of poverty and distress, but has a wider signification, which embraces the improvement and promotion of the happiness of man.' . . . New England Sanitarium v. Inhabitants of Stoneham, 205 Mass., 335, 342, 91 N.E. 385, [citation omitted]." (Emphasis supplied.)

[34] Pl. Br. at 17.

181 Neb. 831, 151 N.W.2d 446, 449 (1967).[35]

One court summarized its analysis of whether a nonprofit hospital is charitable as follows:

> "Is there a definite test which can be given? If the purpose of the institution is one which is recognized in law as charitable and if it is not maintained for the private gain, profit, or advantage of its organizers, officers, or owners, directly or indirectly, we think the institution is properly characterized as a charitable one, notwithstanding the fact that it charges for most, if not all, of the services which it may render, so long as its receipts are devoted to the necessary maintenance of the institution and the carrying out of the purpose for which it was organized. . . .

[35] Most other jurisdictions have recognized this principle as well. For example:

> "The legal interpretation of the phrase 'not for profit, but exclusively as charities', is not controlled by free service to the indigent or poor. Nonprofit hospitals which are devoted to the care of the sick, which aid in maintaining public health, and contribute to the advancement of medical science, are and should be regarded as charities." City of Richmond v. Richmond Mem'l Hosp., 202 Va. 86, 116 S.E.2d 79, 84 (1960).

> "[The Swedish Hospital] is a charitable corporation because all of its earnings are devoted to providing care for the sick and afflicted or in the construction of additions and improvements to enlarge its usefulness." Weiss v. Swedish Hosp., 16 Wash. 2d 446, 133 P.2d 978, 980 (1943).

> "Hospitals which are devoted to the care of the sick and injured, which aid in maintaining public health and which make valuable contributions to the advancement of medical science are rightly regarded as benevolent and charitable. A hospital association not conducted for profit which devotes all of its funds exclusively to the maintenance of the institution is a public charity and this is so irrespective of whether patients are required to pay for the services rendered. Butterworth v. Keeler, [citation omitted]; Matter of Mendelsohn, 262 App. Div. 605, 610, 31 N.Y.S.2d 435, 440; Jewish Mental Health Soc. v. Village of Hastings-on-Hudson, 255 App.; Div. 77, 5 N.Y.S. 2d 567, affirmed, 279 N.Y.S.2d 764, 18 N.E.2d 857." People *ex rel.* Doctors Hosp., Inc. v. Sexton, 267 App. 736, 48 N.Y.S.2d 201 (1944), *aff'd mem.*, 295 N.Y. 553, 64 N.E.2d 273 (1945).

> . . . .
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> "'[T]he test of whether an enterprise is charitable is whether it exists to carry out a purpose recognized in law as charitable, or whether it is maintained for gain, profit, or private advantage.'" *So. Methodist Hosp. and Sanitarium v. Wilson*, 51 Ariz. 424, 77 P.2d 458, 462-63 (1938).[36]

Since promotion of health is a charitable purpose, a nonprofit hospital will satisfy these tests unless operated for private gain.

Plaintiffs assert that "[n]onprofit hospitals which do not provide free care are no more charitable than the for-profit hospitals with which they compete. Nonprofit status is not, of course, sufficient in itself to confer charitable status." Pl. Br. at 16 (footnote omitted). Plaintiffs make two fundamental errors in this assertion. First, they ignore the fact that the promotion of health is regarded under the law of charity as a charitable purpose. Second, they ignore the fact that a nonprofit organization operating in furtherance of a charitable purpose is distinguishable from a commercial enterprise by reason of the absence of private profit.

The law, however, has not ignored this distinction. As Mr. Justice Cardozo (then Judge) stated in *Butterworth v. Keeler*, 219 N.Y. 446, 114 N.E. 803, 804 (1916):

> "What controls is not the receipt of income, but its purpose. Income added to the endowment helps to make it possible for the work to go on. It is only

[36] In holding a nonprofit hospital to be a public charity, the court in *McDonald v. Mass. Gen'l Hosp.*, 120 Mass. 432, 21 Am. Rep. 529 (1876), noted that

> "[i]ts affairs are conducted for a great public purpose, that of administering to the comfort of the sick, without any expectation on the part of those immediately interested in the corporation, of receiving any compensation which will inure to their own benefit, and without any right to receive such compensation. This establishes its character as a public charity. Jackson v. Phillips, 14 Allen 539."

when income may be applied to the profit of the founders that business has a beginning and charity an end."

The Court recognized the same principle in *Trinadad v. Sagrada Orden*, 263 U.S. 578, 581 (1924) where it stated:

"[T]he [charitable] exemption is made in recognition of the benefit which the public derives from corporate activities of the class named, and is intended to aid them when not conducted for private gain."

More recently, the Supreme Court of Wisconsin has undertaken to distinguish charitable activities from proprietary business enterprises:

"What distinguishes the benevolent undertaking, *operated not for profit*, from the private operation, operated as a business enterprise? Increasingly, this question is coming to the courts for the interpretation and application of existing statutes to retirement homes for the aged. Most state courts appear to be answering that such providing of paid-for services to aged persons of modest resources and income is an act of benevolence or charity. Such courts adopt what this court, with approval has called '. . . broad definitions of "charitable" ' institutions which do not embody the idea of giving something away free." *Milwaukee Protestant Home v. City of Milwaukee*, 41 Wis. 2d 284, 164 N.W.2d 289, 292 (1969) (emphasis supplied).[37]

[37] This rationale, as applied to hospitals, is found in *Duncan v. Steeper*, 17 Wis. 2d 226, 116 N.W.2d 154, 158 (1962):

"[T]he test of whether an enterprise, such as a hospital, is charitable is its purpose, and that, if its purpose is to heal the sick and relieve the suffering without hope or purpose of gain from its operation, it is charitable. . . .

. . . .

[T]he gain or profit which destroys the charitable character of a corporation is that which inures to the benefit of its member and is not affected by the fact that the corporation's income may exceed its operating expenses."

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Rev. Rul. 69-545 may be more restrictive than the proposition that a nonprofit hospital is per se charitable because the ruling requires further evidence of community benefit, i.e., an open emergency room and the provisions of services to Medicare and Medicaid patients. However, the fact that the law recognizes that a nonprofit hospital, free of private benefit or profit, is charitable without regard to the quantum of free care provided, offers compelling support for the validity of *Rev. Rul. 69-545*. In view of the principles set forth in the decisions discussed above, the Commissioner cannot be said to have exceeded his authority in enunciating the criteria for charitable hospitals set forth in *Rev. Rul. 69-545*.

F. Rev. Rul. 69-545 Is Consistent with the Rationale for Tax Exemption Under Section 501(c)(3).

Although, as indicated above, the criteria of *Rev. Rul. 69-545* are consistent with the legal requirements for exemption of "charitable" hospitals under section 501(c)(3), plaintiffs attempt to refute this position by shifting ground from the question of what are charitable purposes to the question of what is the basis for exemption of organizations operating in the furtherance of charitable purposes.

They assert that tax exemption of charitable organizations is "conferred on the theory that the charitable organizations are performing functions which would other-

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Accord, Riverview Hosp. v. City of Tomahawk, 243 Wis. 581, 584, 11 N.W.2d 188, 189 (1943), stating with respect to whether a hospital is exempt from property tax as a charitable institution:

"The test is its origin and the objects of its organizers, its complete dedication to charitable purposes and absolute divorce from gain to those controlling ownership." *Accord*, Assoc. Hosp. Services, Inc. v. City of Milwaukee, 13 Wis. 2d 447, 109 N.W.2d 271 (1961); Rueda v. Union Pac. Ry., 180 Ore. 133, 169, 175 P.2d 778, 793 (1946).

wise need to be performed by government and are, therefore, lessening the burdens of government." Plaintiffs go on to conclude that nonprofit hospitals which do not provide free or below cost care are not lessening the burdens of government and are therefore not entitled to tax exemption. Pl. Br. at 15-16.

Plaintiffs' statement is inaccurate in two respects: first, the concept of "lessening of burdens of government" is a rationale for tax exemption which does not represent the prevailing legal view, and, second, in any event, a tax exempt organization may lessen the burdens of government by carrying on charitable activities other than those which relieve poverty.

Lessening of the burdens of government is but one of two rationale for the granting of tax exemptions.[38] The other rationale is that tax exemption is granted to encourage humanitarian and other socially desirable activities

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[38] Referring to these two rationale for granting tax exemption, one author has commented that:

> "One suggested motive for [tax] exemptions is the desire to assist organizations doing the state's work since the state will not lose and will gain if loss in revenue is exceeded by savings resulting from private performance of functions that would otherwise be the state's responsibility. A more generous theory which has been imputed to the legislature is that the state should encourage not only functions easing the state's burden, but all activities devoted to humanitarian goals." Note, *Exemption of Educational, Philanthropic and Religious Institutions from State Real Property Taxes*, 64 HARV. L. REV. 288, 288-89 (1950) (footnotes omitted).

Accord: "The decisions recognizing tax exemption are rested principally upon the conclusion that people in later years have special care and residential requirements, the alleviation of which is of social value; and that exemption should be allowed where such needs are being met by institutions not organized or operated for private profit." Hilltop Village, Inc. v. Kirtland Independent School District, 426 S.W.2d 943, 947-48 (Tex. 1968). *See also* Note, *Humanitarian Approach to Taxation of Homes for the Aged*, 4 WILLAMETTE L. J. 504 (1967).

by the private sector,[39] and this rationale is clearly the prevailing basis for tax exemption.[40] A classic statement of the basis for the humanitarian approach was made by Chief Justice Marshall in *Dartmouth College v. Woodward*, 17 U.S. (4 Wheat.) 518, 637 (1819). Referring to Dartmouth College, he stated that "[t]he objects for which a corporation is created are universally such as the government wishes to promote. They are deemed beneficial to the country; and this benefit constitutes consideration, and, in most cases, the sole consideration of the grant."

For example, the longstanding exemption of churches from Federal income and real property taxation is not based on the "public burden" rationale for tax exemption. Churches have never been exempt because they relieve the state of an economic burden.[41] "Consequently, courts

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[39] Note, *Exemption of Educational, Philanthropic and Religious Institutions from State Real Property Taxes*, 64 HARV. L. REV. 288, 288-89 (1950). *Accord*, Y.M.C.A. v. Los Angeles County, 35 Cal. 2d 760, 221 P.2d 47, 52 (1950).

[40] The jurisdictions which recognize that promotion of health (or relief of the distress of the sick or aged) is a charitable purpose have adopted the humanitarian approach. *See* Sec. I, B-D *supra*. In addition, most jurisdictions have indicated approval of this rationale in their exemption of homes for the aged. R. BROMBERG, *Charity and Change: Current Problems of Tax Exempt Organizations in Perspective*, TAX PROBLEMS OF CHARITIES 1970, at 249 (Webster & Lehrfeld eds. 1970) and the cases at 265 n. 41. Note, *Humanitarian Approach to Taxation of Homes for the Aged*, 4 WILLAMETTE L. J. 504, 510 (1967). *See also* Bromberg, *Non-profit Homes for the Aged: An Analysis of Their Current Tax Exempt Status*, 38 J. TAX. 54 (1973).

[41] Walz v. Tax Comm'n, 397 U.S. 664, 675 (1970). Although the issue before the Court was whether the state tax exemption of churches was a violation of the religion clauses of the First Amendment, many of the statements in that decision bear upon the issue now before the Court and provide support for the humanitarian approach under consideration. In the majority opinion, the Court stated that New York State has "granted exemption to all houses of religious worship within a broad class of property owned by nonprofit, quasi-public corporations which include hospitals, libraries, playgrounds, scientific, professional,

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are compelled to justify exemption of property used for religious purposes on the basis of a separate rationale often referred to as the 'humanitarian doctrine' of tax exemption."[42]

Tax exemptions and charitable deductions relating to foreign charities and charitable activities also illustrate the pervading "humanitarian" rationale behind tax exemption. Domestic corporations may qualify for tax exemption even though all of their charitable activities are carried on abroad. *Rev. Rul. 71-460*, 1971-2 CUM. BULL. 231. Foreign charities can qualify for Federal income tax exemption even if organized and operated for charitable purposes outside the United States and can also receive

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historical and patriotic groups. The State has an affirmative policy that considers these groups as beneficial and stabilizing influences in community life and finds this classification useful, desirable, and in the public interest." *Id.* at 680. Mr. Justice Brennan, concurring, also considered the rationale for tax exemption, encompassing both the lessening of burdens of government theory suggested above (see discussion footnote 38 *supra*) and the classic humanitarian approach to tax exemption of charitable institutions.

> "Government has two basic secular purposes for granting real property tax exemption to religious organizations. First, these organizations are exempt because they, among a range of other private, nonprofit organizations contribute to the well-being of the community in a variety of nonreligious ways, and thereby bear burdens that would otherwise have to be met by general taxation, or be left undone, to the detriment of the community . . . .
>
> . . . .
>
> "Second, government grants exemptions to religious organizations because they uniquely contribute to the pluralism of American society by their religious activities. Government may properly include religious institutions among the variety of private, non-profit groups that receive tax exemptions, for each group contributes to the diversity of association, viewpoint, and enterprise essential to a vigorous, pluralistic society." *Id.* at 687, 689.

[42] Note, *Humanitarian Approach to Taxation of Homes for the Aged*, 4 WILLAMETTE L. J. 504, 509 (1967).

grants from domestic private foundations. Treas. Reg. §1.509-2(a); Treas. Reg. §53.4945-5(a)(5); Treas. Reg. §53.4942(a)-3(a)(6); *Rev. Proc. 59-31*, 1959-2 CUM. BULL. 949. Furthermore, estate and gift tax provisions permit charitable gifts and bequests to be made directly to foreign charitable corporations. Code §2055(a); Code §2522(a). All these foreign activities, which still permit certain tax benefits, certainly do not lessen any burden of the United States government.[43]

Even assuming, arguendo, the applicability of the "public burden" rationale ascribed by plaintiffs, that rationale is not limited to the relief of poverty. If it were, there would be no explanation for the underlying rationale for tax exemption for the broad range of other types of charitable organizations which perform humanitarian and socially desirable functions, but which do not in any respect relieve poverty.[44]

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[43] Plaintiffs attempt to buttress their "public burden" rationale by reference to legislative history which deals with the Code provision limiting the deductibility of individual contributions to domestic charities. Pl. Br. at 15 n. 9. Although the legislative history cited by plaintiffs does limit the charitable deductions for income tax purposes to domestic organizations, it does not limit the use of the funds received by such organizations to distribution within the United States. "If the recipient, however, is a domestic organization the fact that some portion of its funds is used in other countries for charitable and other purposes (such as missionary and educational purposes) will not affect the deductibility of the gift." H. R. REP. No. 1860, 75th Cong. 3d Sess. 19-20 (1938). The well established law governing contributions, gifts and bequests to or for the use of foreign charities and the tax-exempt status of such organizations, as discussed in the text, belies any attempt to extend plaintiffs' rationale to an all-inclusive statement of the basis for tax exemption of every charitable institution. See Eaton, *Charitable Foundations Making Grants Abroad*, 17 TAX L. REV. 41 (1961).

[44] The following are some of the organizations operating for the benefit of the community which are recognized by IRS as entitled to tax exemption as charitable organizations without reference to relief of poverty: Rev. Rul. 68-164, 1968-1 CUM. BULL. 252 (organization formed to promote safety in small boat con-

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The legislative history under section 170 referred to by plaintiffs (Pl.Br. at 15 n. 9) does not even support plaintiffs' characterization.[45] Its language does not limit the "public burden" rationale to activities which relieve poverty. Rather it suggests that there are certain activities which might better be accomplished through private nonprofit organizations which receive contributions from the public than through direct governmental action.[46]

Thus under the "public burden" rationale, exemption is granted to encourage the private nonprofit sector to assume certain functions, not limited simply to the relief of poverty, which would otherwise have to be per-

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struction and operation); Rev. Rul. 66-46, 1966-1 CUM. BULL. 133 (organization formed to promote public appreciation of group harmony singing); Rev. Rul. 65-271, 1965-2 CUM. BULL. 161 (organization created to develop and promote an appreciation of jazz music); Rev. Rul. 64-174, 1964-1 CUM. BULL. 183 (organization for establishment of repertory theatre); Rev. Rul. 67-292, 1967-2 CUM. BULL. 184 (organization developing sanctuary for wild birds and animals); Rev. Rul. 71-545, 1971-2 CUM. BULL. 235 (organization conducting international exposition); Rev. Rul. 65-191, 1965 CUM. BULL. 157 (organization operating community center); Rev. Rul. 70-640, 1970 CUM. BULL. 117 (organization providing personal marriage counseling services); Rev. Rul. 66-146, 1966-1 CUM. BULL. 136 (organization to encourage and recognize outstanding achievements and contributions of citizens); Rev. Rul. 64-275, 1964-2 CUM. BULL. 142 (organization formed to train candidates in sailboat racing techniques); Rev. Rul. 68-70, 1968-1 CUM. BULL. 194 (organization formed to advance equal job opportunities). See also revenue rulings based upon promotion of health as a charitable purpose cited under footnote 19 *supra*. For similar examples in Federal cases, *see* Bok v. McCaughn, 42 F.2d 616 (3d Cir. 1930); Broadway Theatre League v. United States, 293 F.Supp. 346 (D.C. Va. 1968).

[45] H. REP. No. 1860, 75th Cong., 3d Sess. 19-20 (1938).

[46] *E.g.*, "[T]he government exempts [charitable institutions] from paying taxes because if such enterprises did not exist the government would be required to use tax dollars to do the job the charitable enterprises are now doing." Friendsview Manor v. State Tax Comm'n, 247 Ore. 94, 420 P.2d 77, 82 (1966).

formed by government.[47] This is particularly true in the case of hospitals.

> "[C]onduct of a hospital has long been thought of as a legitimate function of government in preserving the health of the community. Additional weight has been given this proposition by the many cases which state that one of the bases of the tax exemption of charitable hospitals is that they relieve the state of the burden of providing hospital services and are, therefore, performing a quasi-governmental function."[48]

Without voluntary nonprofit hospitals, government would be forced directly to provide hospital care for our entire population. Indeed, one court has stated that "[e]liminate hospitals from our cities and our cities would vanish."[49] Therefore, under either the "public burden" rationale or the "humanitarian" rationale, tax exemption for voluntary nonprofit hospitals is justified without regard to the provision of free or below cost care.[50]

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[47] ". . . the principal justification for tax benefits granted to these organizations and their donors should be that they relieved the government of what might otherwise be government functions which are better accomplished in this fashion than they would be through direct government expenditures of grants." Stone, *Federal Tax Support of Charities and Other Exempt Organizations: The Need for a National Policy*, 20 So. CAL. TAX. INST. 54 (1968).

[48] Horty, *Public Purpose Is The Key To Tax Exemption*, 106 MOD. HOSP. 60, 62 (March 1966).

[49] Ellis v. City of Grand Rapids, 257 F. Supp. 564, 572 (S.D. Mich. 1966):

> "When public, private and sectarian hospitals practice mercy toward men, they at the same time perform prime sectarian works and incomparable public services. Eliminate hospitals from our cities and our cities would vanish.
>
> "Promotion and improvement of our peoples health . . . is a fundamental obligation of governments, national, state and local . . . . The Congress of the United States and the state legislatures of the several states have in a multitude of ways established means to provide and care for the health of the people."

[50] "The general trend of authority in cases determining the

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II. THE MODERN LEGAL DEFINITION OF A CHARITABLE HOSPITAL REFLECTS THE HISTORICAL EVOLUTION OF THE VOLUNTARY NONPROFIT HOSPITAL FROM ALMSHOUSE TO COMMUNITY HEALTH FACILITY.

The "mistaken view," espoused by plaintiffs, that a charitable hospital must provide free care to indigents is an anachronism which can be traced to the origins of our early hospitals and their subsequent development. Because this view nevertheless still persists in a minority of jurisdictions, the prevailing contemporary criteria for a charitable hospital expressed in *Rev. Rul. 69-545* can best be understood through an analysis of the historic development of the hospital as an institution and the response of the law of charity to changes in the functions and financing of that institution.

A. The Law of Charity Responds to the Changing Needs of Communities and the Institutions Which Serve Them.

The courts have consistently recognized that, in order to retain its vitality, "[t]he scope of charity and the standards under which it is administered are not frozen by the past, but keep pace with the times and the new conditions and wants of society."[51] Construing language identical to

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charitable character of institutions for tax exemption veers away from the old concept that charity is confined to the 'free' care of the indigent, and toward the idea of charity as comprehending all humanitarian activities even though recipients may be able to pay at least in part for the benefits." Ann., *Receipt of Pay from Beneficiaries as Affecting Tax Exemption of Charitable Institutions*, 37 A.L.R. 3d 1191, 1197 (1971).

[51] Bozeman Deaconess Found. v. Ford, 151 Mont. 143, 439 P.2d 915, 918 (1968). *Accord*, G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES §369, at 62-63 (2d ed. 1964); C. ZOLLMANN, AMERICAN LAW OF CHARITIES 121, 123 (1924); Note, *Humanitarian Approach to Taxation of Homes for the Aged*, 4 WILLAMETTE L. J. 504, 507 (1967).

section 501(c)(3) in another act, *i.e.*, whether a corporation "was organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes" under section 1(b)(7) of the District of Columbia Unemployment Compensation Act, the Court of Appeals for the District of Columbia applied this fundamental principle.

> "'. . . the differing condition, character, and wants of communities and nations change and enlarge the scope of charity, and where new necessities are created new charitable uses must be established. . .'"[52]

This principle has been recognized as applicable to changes in the hospital area:

> "[r]easonable deviations and expanded interpretations must be made from time to time in order to keep pace with changes in recognized concepts of the proper sphere of general hospital operations." *Charlotte Hungerford Hosp. v. Mulvey*, 26 Conn. Sup. 394, 225 A. 2d 495, 497 (1966).

Unless the courts and the Commissioner, in recognition of their decisions, are free to recognize this basic principle of the law of charity by modifying the requirements for exemption under section 501(c)(3) in response to changing economic, technological and social conditions, the charitable exemption provided by Congress in section 501(c)(3) will surely lose its vitality and its ability to encourage new endeavors beneficial to the changing needs of man.[53]

[52] Collier v. Lindley, 203 Cal. 641, 266 P. 526, 528 (1928), cited in Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337, 339 (D.C. Cir. 1942). *Accord*, Green v. Connally, 330 F. Supp. 1150, 1158-59 (D. D.C. 1971); Todd v. Citizens Gas Co., 46 F.2d 855, 965, (7th Cir.), *cert. denied*, 283 U.S. 852 (1931): "[t]he enforcement of charitable uses cannot be limited to any narrow and stated formula. It must expand with the advancement of civilization and the daily increasing needs of man."

[53] R. BROMBERG, *Charity and Change: Current Problems of Tax Exempt Organizations in Perspective*, TAX PROBLEMS OF

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B. Early Hospitals Were Almshouses.

From its inception, the hospital was principally a custodial institution for unwanted members of society—the sick, the poor, the wanderers, the displaced, the incurables and the infectious.[54] Its principal purpose was to serve the indigent, with medical care being incidental.

The first hospitals in America were said to be "pest houses" for sailors with contagious diseases, one being established in Manhattan in 1663 and one in Philadelphia in 1731.[55] The Philadelphia General Hospital, which grew out of the Philadelphia Almshouse founded in 1713, and its early successors during the 18th century were essentially almshouses and provided facilities for indigents, criminals, foundlings, the physically handicapped, and the mentally unbalanced.

Our early "charitable" hospitals were not institutions primarily concerned with delivering health care to the sick, but were basically almshouses providing the barest

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CHARITIES 1970 249 (Webster & Lehrfeld eds. 1970). Some recent examples of organizations which have been held exempt under section 501 (c) (3), even though their purposes, or their means of achieving them, were not recognized as charitable under prior law are: public interest law firms, Rev. Proc. 71-39, 1971-2 CUM. BULL. 575; women's liberation organizations, Rev. Rul. 72-228, 1972-1 CUM. BULL. 148; day care centers, Rev. Rul. 70-533, 1970-2 CUM. BULL. 112; drug abuse centers, Rev. Rul. 70-590, 1970-2 CUM. BULL. 116; environmental protection organizations, Rev. Rul. 72-560, 1972-2 CUM. BULL. 248; home health care organizations, Rev. Rul. 72-209, 1972-1 CUM. BULL. 148; marriage counseling organizations, Rev. Rul. 70-640, 1970-2 CUM. BULL. 117; community land use planning organizations, Rev. Rul. 67-391, 1967-2 CUM. BULL. 190; and abortion counseling organizations, Rev. Rul. 73-569, 1973-2 CUM. BULL. 178.

[54] The oldest known hospital in Western Europe was the Hotel Dieu, founded at Lyons in 542 A.D. It served as an inn, workhouse, asylum and infirmary. *See* C. LETOURNEAU, HOSPITAL TRUSTEESHIP 4 (1959); COMM'N ON HOSPITAL CARE, HOSPITAL CARE IN THE UNITED STATES 425 (1947); J. KNOWLES, HOSPITALS, DOCTORS AND THE PUBLIC INTEREST (1965).

[55] *See* MARTS, THE GENEROSITY OF AMERICANS 114-15 (1966).

refuge for the poor members of society who had no place else to go.[56] Pay patients were unheard of because those who could afford care remained at home to avoid the harsh and unsanitary conditions in these early "charitable" institutions.[57].

The origin of American hospitals as almshouses was reflected in the law of charities well into the early part of the 20th century. Decisions dealing with the definition of a charitable hospital had little difficulty in characterizing such institutions as organizations dedicated exclusively to the care of the poor and indigent since this, in fact, was precisely how these institutions had functioned in Europe and America. Thus, charitable hospitals were frequently indistinguishable from almshouses in early legal definitions. For example, in construing an exemption from taxation for every "poor-house, house of industry, *almshouse*, and every house belonging to a company incorporated for the reformation of offenders," a New York Court found that a private hospital qualified as an almshouse. *In re Curtis' Est.*, 1 Con. 471, 7 N.Y.S. 207 (Surr. Ct. 1889).[58] As

[56] E. FISCH, D. FREED AND E. SCHACHTER, CHARITIES AND CHARITABLE FOUNDATIONS §322 (1974). The workhouse for the impecunious aged was the historic antecedent for today's homes for the aged, posing a similar problem for the self-supporting home for the aged of today.

[57] Bromberg, *The Charitable Hospital*, 20 CATH. U. L. REV. 237 (1970). As noted by one authority:

> "General hospitals were established in the United States as early as the eighteenth century to serve the sick poor, and offer a roof and bed for the homeless or for those whose homes were inadequate. These institutions were primarily the last resort of the sick. Their standards of care did not approach those for the simplest custodial care today. Hospital cleanliness was unknown, nursing was unskilled, equipment did not even include the clinical thermometer." *Factors Affecting the Costs of Hospital Care*, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES 9 (J. Hayes, ed. 1954).

[58] *Factors Affecting the Costs of Hospital Care*, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES (J. Hayes, ed. 1954).

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late as 1926, the Supreme Court of Oklahoma held that " '[a] public hospital is a charitable institution, or under some statutes, an almshouse, so as to be exempt from taxation. . .' " *S.W. Osteopathic Sanitarium v. Davis*, 242 P. 1033, 1034 (Okla. 1926).

In view of the historic role of the hospital as an almshouse, it is not difficult to understand the derivation of the common law rule that "[t]he first concern of a public charitable hospital must be for those who are unable to pay." *O'Brien v. Physicians' Hosp. Assoc.*, 96 Ohio St. 1, 116 N.E. 975, 977 (1917). Similarly, in view of the fact that any person able to afford medical care would avoid these early institutions which functioned solely for the poor, it is not surprising that a companion rule developed that the presence of pay patients was antithetical to exemption of hospitals as charitable institutions.[59]

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"The primary meaning of the word 'hospital' for instance, was an inn. . . . Now the word is more commonly applied to a building founded for charity, where the sick and disabled may be treated solely at their own expense, or at the expense of the Corporation which receives only indigent patients, *and then has all the attributes of an almshouse*, and in either case it becomes, as we understand the terms, a charitable institution." (Emphasis supplied.)

[59] In deciding that a nonprofit hospital was not charitable, the Supreme Court of Mississippi quoted with approval the stipulated statement of facts:

" 'From time to time, [the hospital] treats charity patients, but care of such patients is not its principal purpose; its primary purpose is to care for and treat patients for pay. Its entire property is devoted to the care of the sick, and to those who require medical or surgical treatment.' " Mayor and Aldermen of City of Vicksburg v. Vicksburg Sanitarium, 117 Miss. 709, 78 So. 702 (1918).

Similarly, as late as 1933, the Supreme Court of Georgia held that a hospital supported in substantial part by donations and largely by income derived from pay-patients received in the hospital is not within the exemption for institutions of purely public charity, although it also received without charge certain patients who are unable to pay. Richardson v. Exec. Comm. of Baptist Conv., 176 Ga. 705, 169 S.E. 18 (1933).

The correlative of these rules reflecting the almshouse or pesthouse function of the charitable hospital was that private contributions would be received by these institutions to underwrite the cost of caring for the poor.[60] Although tax funds contributed to their operations, philanthropy and endowment earnings were also important sources of financing the cost of indigent care.[61]

This pattern of financing the cost of health care for the poor was also reflected in our early decisions. In 1881 the Supreme Court of Minnesota held "that an institution established, maintained and operated for the purpose of taking care of the sick, without any profit, or view to profit, but at a loss which has to be *made up by benevolent contributions*, is a charity." *In re Lots 8 and 9*, 27 Minn. 460 (1881)[62] (emphasis supplied). Thus, in response to the modus operandi of our early voluntary nonprofit hospitals, American case law reflects certain basic criteria for qualification of nonprofit hospitals as charitable institutions:

(1) Their primary concern must be with indigent patients;

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[60] "Voluntary hospitals were a form of charitable agency not connected with church or state. They were founded by gifts and subscriptions collected from donors who have an interest and pride in civic affairs and a desire to participate in philanthropy. They were maintained by these funds. . . ." COMM'N ON HOSPITAL CARE OF THE COMMONWEALTH FOUNDATION, HOSPITAL CARE IN THE UNITED STATES 442 (1947).

[61] "At the end of the nineteenth century there were a few private institutions of the sanitarium type exclusively for pay patients, but the great majority of hospital patients were still the poor who received their care free or who paid only a portion of the cost. Tax funds, philanthropy and endowment earnings were the chief sources of hospital financing." *Factors Affecting the Costs of Hospital Care*, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES 12 (J. Hayes, ed. 1954); *see also* MCNERNEY, *Health Research and Educational Trusts*, 1 HOSPITAL AND MEDICAL ECONOMICS 92 (1962).

[62] "A hospital which pays no dividends and is largely supported by donations is a charitable institution." *In re* Prange's Will, 208 Wis. 404, 243 N.W. 488, 491 (1932).

(2) They may not serve a substantial number of pay patients;

(3) They are required to provide a substantial amount of free care; and

(4) They are required to receive contributions and maintain endowments to underwrite the cost of caring for the poor.

C. Voluntary Hospitals Began to Develop into Community Health Facilities During the 19th and Early 20th Centuries.

The 19th century brought the beginning of two major changes in hospital care in America. The first was the development in the early part of the century of the voluntary hospital with its community, rather than indigent, orientation. The second, which began in the latter part of the 19th and continued over into this century, was the improvement of conditions in hospitals.

By the middle of the 19th century, a number of voluntary hospitals had developed in this country. Unlike the older almshouse form of institution, their primary purpose was to serve the sick and injured regardless of economic status, race, color or creed.[63] By the end of the 19th century, the need for voluntary hospitals increased significantly as a result of the introduction of new services such as asepsis and anesthesia.[64] By the turn of the century, hospital

[63] COMM'N ON HOSPITAL CARE OF THE COMMONWEALTH FOUNDATION, HOSPITAL CARE IN THE UNITED STATES 442 (1947).

[64] "One might say that the period from 1880 to 1910 was the golden era of hospital progress and development. It was in that period that modern medical diagnostic techniques and aseptic surgery were developed; professionalism and specialization were brought to anesthesia and to the clinical laboratory. Roentgenology was invented and introduced as a common diagnostic tool.

"These advances led to the expansion of hospital utilization. Facilities were developed for private patients. Any physician

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services began to include expert nursing, diagnostic x-rays, protection against infection, clinical laboratory service, anesthesia and aseptic surgery.[65] Thus, hospitals became community health facilities.

Accompanying this change in function of the hospital from almshouse to a community health facility was a gradual change in the sources of its financial support. Whereas during the last century and the early part of this century, gifts, endowments and tax funds were of greater importance to the operation of voluntary nonprofit hospitals,[66] income from patients began to assume greater significance as hospitals began to be accepted and utilized by the great middle class.[67]

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who wanted the full resources of modern diagnosis and treatment had to have a hospital staff appointment. *The hospital changed from a place caring for the transient and the poor to a place where special services of diagnosis and treatment were available to the physician's patients—the poor and wealthy alike.* From 1873 to 1909, the number of hospitals increased from 178 to 4,359." I. BELKNAP AND J. STEINLE, THE COMMUNITY AND ITS HOSPITALS 13 (1963).

[65] COMM'N ON HOSPITAL CARE OF THE COMMONWEALTH FOUNDATION, HOSPITAL CARE IN UNITED STATES 447 (1947):

> "[T]he public came to realize that certain forms of disease and injury could be better treated in hospitals than in their own homes. By the end of the century, hospitals were admitting increasing numbers of paying patients in special wards and rooms set apart from those for the destitute. Advances in medical science and nursing care gave infallible proof to the public that hospitals were essential to the health of the community."

[66] McNERNY, *Health Research and Education Trusts*, 1 HOSPITAL AND MEDICAL ECONOMICS 9 (1962).

[67] Prior to 1900, the earnings for patients' fees in hospitals holding membership in the United Hospital Fund of New York City covered but a third of the expenses, but thirty years later, the figure was sufficient to meet two-thirds of the cost of operations. The percentage of income from paying-patients throughout the century doubled in a generation. M. DAVIS, CLINICS, HOSPITALS AND HEALTH CENTERS 13 (1927).

However, during the 19th century and continuing into this century, the patient in the private room was not merely a "pay patient," but was in reality an "overpay" patient in accordance with the Robin Hood theory that persons able to pay should be charged enough to supplement the funds available for hospital care of the poor. This was the beginning of the trend toward less reliance by charitable hospitals upon voluntary philanthropy and more reliance upon involuntary philanthropy in the form of overcharges to pay patients to cover the cost of operating expenses for indigent care. The social welfare legislation under which the Government began to assume a substantial part of the cost of indigent care on a wide-spread basis had not yet flowered.[68]

Thus, moving into the middle of the 20th century, the voluntary hospital had changed its function to a community health facility available to pay patients. Its sources of financing indigent care, although still dependent upon philanthropy, had shifted toward using receipts from the excess of charges to pay patients over the cost of the services rendered.

This transition was also reflected in the attitude of the law of charity towards the charitable hospital. Moving away from the position that the presence of pay patients is antithetical charitable status, a new rule developed in the law.

> "[T]he mere fact that pay patients predominate over those unable to pay, and that charges are made for drugs furnished those of the patients able to pay for them, and that charges are made against those able to pay for the use of the operating rooms, does not destroy or impair the exclusiveness of the use of the property by the [hospital], nor does it change the character of the institution from one of purely public charity." *Santa Rosa Infirmary v. City of San Antonio*, 259 S.W. 926, 934-35 (Comm. App. Tex. 1924).[69]

Courts began to reject the argument that a "hospital should not be held to be an institution of public charity by reason of the great disparity between the number of charity patients and those who pay for the care and attention they receive at this institution." *Sisters of Third Order of St. Francis v. Bd. of Rev.*, 231 Ill. 317, 83 N.E. 272, 273-74 (1907).

In recognition of the fact that nonprofit hospitals had now begun to serve paying patients, instead of only indigents, the concept developed that a charitable hospital was one which served the rich as well as the poor.[70] The classic statement of this rule, as enunciated in *Nuns of Third Order of St. Dominic v. Younkin*, is:

> "When an institution is incorporated for benevolent purposes without capital stock, and no dividends are declared or paid, and conducts a hospital, and all the earnings of the hospital from pay patients, gifts, devises, bequests or whatever source are used in the maintenance, extension and improvement of the hospital, and which admits patients without regard to race, creed, or wealth, it is uniformly held that such hospital is conducted exclusively for charitable purposes." 118 Kan. 554, 235 P. 869, 872 (1925).[71]

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[68] E. FISCH, D. FREED AND E. SCHACHTER, CHARITIES AND CHARITABLE FOUNDATIONS §322, at 274 (1974):

> "During the middle of the past century, hospitals began to change from asylums for the poor to large centers where physicians furnished expert medical services to all who required medical attention. Gradually, the government entered into the field of health and hospitals began to receive financial support from public sources." (Footnote omitted.)

[69] *Accord*, Dingwell v. Seymour, 91 Cal. App. 483, 267 P. 327 (1928); State *ex rel.* Cunningham v. Bd. of Assessors, 52 La. Ann. 223, 26 So. 872 (1898).

[70] *See* Pl. Br. at 29.

[71] *Accord*, Bishop v. Treas., 37 Colo. 378, 86 P. 1021 (1906); Sisters of Third Order of St. Francis v. Bd. of Rev., 231 Ill. 317, 83

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At the same time that the courts were sanctioning the use of charitable hospitals for paying patients, they began to develop the doctrine that a nonprofit hospital, free of private benefit or profit, was, per se a charitable institution. This doctrine reflected both the well-established legal premise (discussed above) that the promotion of health is a charitable purpose and the fact that pay patients had now become a source of funding hospital operations.

While the earliest expression of this concept was directed towards the use of excess charges to pay patients to fund free care,[72] as hospitals continued to develop into the 20th century and expand their functions as the community health facility, the rule began to evolve into the present state of the law's recognition that a nonprofit hospital, free of private profit, can qualify as charitable, even if it charges all patients.[73] This is the derivation of the rule enunciated by Scott and other treatise writers that

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N.E. 272 (1907); German Hosp. v. Bd. of Rev., 233 Ill. 246, 84 N.E. 215 (1908); State *ex rel.* Alexian Bros. Hosp. v. Powers, 74 Mo. 476 (1881); State v. Collector of Chatham, 52 N.J.L. 373, 20 A. 292 (1890). To the same effect under Federal law, *see* Gossett v. Swinney, 53 F.2d 772, 776 (8th Cir. 1931), *cert. denied*, 286 U.S. 545 (1932):

"Perhaps charity, as generally and commonly understood, has to do with gifts to the poor and needy, and steps taken to relieve distress and suffering on the part of those unable to help themselves; but the legal significance of the term is much broader. Public charities are thus defined: 'Every public trust, though benefiting the rich and the poor alike, is a charitable trust.'"

[72] "The increase of charitable funds, through receipts from patients or inmates who are able to pay wholly or partially for benefits received, does not change a home for aged people, or hospital, organized and conducted as a charity, into a private association, maintained for the pecuniary advantage of the promoters. The originally eleemosynary character of the institution is not transformed by this patronage, even if sufficient to relieve it from financial burdens, but the charity as established remains unaffected." New England Sanitarium v. Inhabitants of Stoneham, 205 Mass. 335, 91 N.E. 385, 387 (1910).

[73] As early as 1934, in a landmark case in the law of charity,

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"[a] trust to establish or maintain an institution may be charitable, however, although it is provided that some or *all* of the persons to receive benefits from the institution are to pay fees or otherwise contribute to the expense of maintaining the institution." (Emphasis supplied.)[74]

D. The Financing of Hospital Care Has Shifted to Reimbursement by Private and Governmental Third Parties.

The modern legal view of a charitable hospital reflects not only the evolution of the voluntary hospital from

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the Supreme Court of Vermont held: "The fact that none of its [the hospital's] patients are cared for without charge does not deprive it of its charitable feature." Brattleboro Retreat v. Town of Brattleboro, 106 Vt. 228, 173 A. 209, 212 (1934).

In another case from the same period, the Supreme Court of Texas stated:

"[T]he mere fact that pay patients largely predominated over the charity patients, or that the institution did not go out into the highways and byways seeking out those to whom its charitable offices might be extended, could not, under the great weight of authority, be said to so detract from its charities as to disqualify it as an institution of purely public charity." Santa Rosa Infirmary v. City of San Antonio, 259 S.W. 926, 932 (Comm. App. Tex. 1924).

Even the Supreme Court of Ohio appears to have recognized the transition in the role of the community hospital by moving away from the rule that "the *first concern* of a public charitable hospital must be for those who are unable to pay" (O'Brien v. Physicians' Hosp. Assoc., 96 Ohio St. 1, 116 N.E. 975, 977 (1917) (emphasis supplied)) to the rule that "a hospital to qualify as a charitable institution, the property of which is exempt from taxation, should have as *an important objective* the care of the poor, needy and distressed who are unable to pay, although the fact that it admits and ministers to a number of pay patients will not necessarily destroy its charitable character." Cleveland Osteopathic Hospital v. Zangerle, 153 Ohio St. 222, 91 N.E.2d 261, 264 (1950).

[74] A. Scott, The Law of Trusts §376, at 2966 (3d ed. 1967); *see also id.* at 2966-68 n. 3; C. Zollmann, American Law of Charities §714-15 (1924).

almshouse to community health facility, but more importantly the evolution of the means of financing hospital care. As we move into the last half of the 20th century, further important changes occurred in the delivery of hospital care. These include:

(1) A rapid increase in patient income, with a corresponding increase in the percentage of expenses covered by revenues from paying patients as compared to revenues from charitable contributions.[75]

(2) A substantial increase in the cost of hospital care because of higher wages and improved medical technology.[76]

(3) The rapid growth of health insurance to meet the increasing costs of hospital and medical care.[77]

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[75] "The most significant shift in the source of income of nonprofit general hospitals was the sharp increase in the proportion of funds received from or on behalf of patients. Income from patients made up 71 percent of total income in 1935, but accounted for 89 percent in 1952. Total patient income increased 746 percent over this 17 year period, contrasted with an increase of only 163 percent in income from all other sources." *Factors Affecting the Costs of Hospital Care*, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES 53 (J. Hayes, ed. 1954).

[76] G. BAEHR, *Medical Care: Old Goals and New Horizons*, 3 MEDICAL CARE AND TRANSITION 326 (1967); DEPT. HEALTH, EDUC. & WELFARE, REPORT OF SECRETARY'S ADVISORY COMM. ON HOSP. EFFECTIVENESS 6 (1968).

[77] *See* H. KLARMAN, THE ECONOMICS OF HEALTH 31 (1965). By 1940 only 9.3% of our population had some form of hospital insurance. Mueller, *Private Health Insurance in 1973: A Review of Coverage, Enrollment and Financial Experience*, 38 Soc. Sec. BULL. 21, at 26, Table 6 (Feb. 1975); DENSON, BALAMUTT AND SHAPIRO, PREPAID MEDICAL CARE AND HOSPITAL UTILIZATION 1 (1958). However by 1973, under estimates of the Health Insurance Association of America, approximately 87.1% of the civilian population was covered by some form of private health insurance. Mueller, *Private Health Insurance in 1973*, *supra* at 26, Table 6 (Feb. 1975). Even these figures do not include persons eligible for health insurance under Medicare. In 1970, it is

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(4) The rapid growth of health insurance coverage for the poor under Medicare and Medicaid.[78]

(5) The resulting decline in the percentage of free or below-cost patients requiring hospital care.[79]

In the light of these changes, the common law rules developed for charitable hospitals of the 18th and 19th centuries, being primarily concerned with free care to indigents, are no longer applicable to community hospitals in 1975. In recognition of the importance of health care to its citizens, federal, state and local governments, through the enactment of legislation providing reimbursement to

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estimated that an additional .59% of those not otherwise covered by health insurance received benefits under Medicare (Department of Commerce figures from A GUIDE TO CONSUMER MARKETS, CONFERENCE BOARD REPORT, No. 67, at 140), and another 8.6% received benefits under Medicaid (NUMBER OF RECIPIENTS AND AMOUNTS OF PAYMENTS UNDER MEDICAID 1970, DHEW Publ. No. (SRS) 73-03153MCSS Report B-41(CY 70) p. 1). Thus during the early 1970's estimated figures indicate that some form of health insurance coverage, either private or public, was available to over an estimated 96% of the population.

[78] Cantor, *The Law and the Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901, 914 (1970):

> "At the same time as the focus of hospital patient care was shifting from the poor population toward the general public, the source of hospital funding was changing. Massive infusions of public monies began, ending the reliance on private contributions and eventually reaching the point where today approximately fifty per cent of the private hospitals' operating funds are derived from governmental sources."

In 1973, Medicaid payments were made on behalf of an estimated 20.9 million persons. Mueller, *Private Health Insurance in 1973: A Review of Coverage, Enrollment and Financial Experience*, *supra* at 22. As of January 1, 1973, the total number enrolled for hospital care under Medicare was 21 million people.

[79] "The decrease in charity service provided by hospitals may have resulted in part from a tendency in some areas for government to assume greater responsibility for the care of the indigent through direct payment for individual Cases . . . " *Factors Affecting the Costs of Hospital Care*, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES 56 (J. Hayes, ed. 1954).

health care providers[80] and the maintenance of a system of public hospitals, have evidenced an increasing acceptance

[80] The number of persons covered by Medicare can be readily determined by looking to the number of persons enrolled in the program. However, since Medicaid coverage is available to all persons who come within the state requirements for coverage, an indigent person eligible for Medicaid, but has not become sick and availed himself of its benefits, will not be reflected in statistics showing the number of Medicaid recipients. Because eligibility for benefits is thus greater than the number of persons who actually receive such benefits, it is not possible to make a precise estimate of the percentage of the population covered. This, and other factors, suggest that a greater number of persons are covered by some health insurance or are otherwise able to pay at least part of the costs of their hospital care than is suggested by plaintiffs (Pl. Br. at 33).

> "Undoubtedly, some Americans who could afford to buy private health insurance choose not to do so. Many other persons receive assistance with these costs through such programs as Medicaid (medical assistance), the civilian health and medical care program for the uniformed services (CHAMPUS), the Veterans Administration Program, State disability insurance programs, and workmen's compensation." Mueller, *Private Health Insurance in 1973: A Review of Coverage, Enrollment and Financial Experience*, 38 Soc. Sec. Bull. 21, 21-22 (Feb. 1975).

Nevertheless, it is not disputed that some Americans are lacking in coverage, or are otherwise unable to pay the full costs of hospital care. What is significant for purposes of the issue before the Court, however, is not the diminishing percentage of persons who are not covered, but rather the dramatic expansion between 1940 and 1973 of coverage from 9% to in excess of an estimated 87% of our population (approximately 96.29% if estimated Medicare and Medicaid coverage is included), and the continuing decrease in the number of patients for whom reimbursement is not available under government programs. These are facts that our courts have taken notice of in evolving a contemporary definition of the charitable hospital. It is these same facts, and the case law reflecting them, that provide a sound legal basis for *Rev. Rul. 69-545*. It is further noted that the enactment of national health insurance is only a matter of time. It will moot the issue before the Court and dramatically illustrate the decline of the charity patient. The free care test for charitable exemption asserted by plaintiffs is totally incompatible with any program of national health insurance and could not be administered by the IRS in such climate on any meaningful basis.

of the role of government in this area[81] and have shifted the burden of paying for free care from private philanthropy.

Although there admittedly are still persons for whom no reimbursement is available, voluntary hospitals' ability to finance the cost of free care for this unfortunate minority has been sharply reduced. Philanthropy initially sustained the cost of free care during the early development of our hospitals, but by 1973 it provided only about 4% of the total health costs, approximately 2/3 of which was earmarked for construction and modernization of facilities, and therefore was not available for operating fund purposes, which includes medical care, research and indigent care."[82]

[81] In *Mem'l Hosp. v. Maricopa County*, 415 U.S. 250 (1974), the Court has insisted that local government assume this burden, while noting the financial plight on voluntary hospitals attempting to share in it.

[82] American Assoc. of Fund Raising Council, Inc., Giving U.S.A. 34 (1973). Of this 4%, approximately 60% is generally spent for hospital construction and modernization of facilities leaving only about 1.3% of philanthropic funds available for all operating needs, including indigent care. *See* Hearings on Medicare and Medicaid before the Subcomm. on Medicare-Medicaid of the Senate Comm. on Finance (Part 2), 91st Cong., 2d Sess. 422 (1970). In fact, "the need for capital is outstripping the philanthropic supply." Walls, *Cost Reimbursement Worsens Capital Crisis*, 46 Hospitals 81 (March 1, 1972).

> "The image of a voluntary institution as a charitable organization, financing its care of patients to a substantial degree through philanthropy . . . is largely anachronistic. Philanthropy, through increasing, has not been able to match the redoubled demands for health care."

Statement of Professor William Thomas, Hearings on Conditions and Problems of the Nation's Nursing Homes. Subcomm. on Long-Term Care, Special Comm. on Aging, U.S. Sen., (Part 2), 89th Cong., 1st Sess., 559 (Feb. 15, 1965).

> "Yet hospitals were historically founded to meet the medical needs of the sick poor. In accordance with the philanthropic motivations of their founders, the charters of innumerable private 'charitable' hospitals explicitly required the rendering of care to all patients who needed assistance, including

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The impossibility of meeting the demands for free care of indigents through philanthropy can be simply illustrated by comparing the 4% of cost of health care met by philanthropy in 1973 with the 23.6 million persons plaintiffs claim need free care. Pl. Br. at 33-34.[83]

The hospitals' other traditional means of financing free care through shifting the burden upon patients paying more than the cost of their own hospital care has also been drastically diminished. Medicare and Medicaid universally, and Blue Cross plans generally, provide reimbursement on the basis of cost. The cost of indigent care is excluded from the reimbursement formula. Only commercial plans and private paying patients pay in excess of cost.

Accordingly, the percentage of hospital expenditures which are reimbursed on the basis of cost, leaving no excess to cover the cost of charitable care, has been steadily increasing, rising from 68.2% in 1970 to 72.8% in 1972.[84] Thus the 27.2% of the patients paying charges would be faced with an extraordinary burden if required to bear the cost of indigent care for an alleged 27 million people.[85]

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the sick poor. Such institutions were sustained by the charitable contributions of the public at large. In many instances fiscal burdens have gradually impeded continuation of the hospital's charitable function and in some instances provoked complete discontinuance of 'free' care." Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901, 914 (1970) (footnotes omitted).

[83] Dividing the $800 million available for operating expenses by hospitals in 1969 (see Pl. Br. at 15) by the 23.6 million persons allegedly needing free care, only $33 per year would be available to subsidize the care of each such person. This would pay for less than one day of hospital care.

[84] 1973 AHA GUIDE TO THE HEALTH FIELDS (Aug. 1973).

[85] "When absorbed by private hospitals, the costs of caring for indigents must be passed on to paying patients and 'at a rather inconvenient time'—adding to the already astronomical costs of hospitalization which bear so heavily on the resources of most Americans." Mem'l Hosp. v. Maricopa County, 415 U.S. 250, 265 (1974).

In summary, the application of principles of the law of charity developed in the 18th and 19th centuries, which plaintiffs would have the Court impose, would require that a charitable hospital primarily concern itself with the poor, although the hospital as an almshouse disappeared nearly a century ago; that a charitable hospital not concentrate its efforts upon caring for the pay patients, although this is the modus operandi of nearly all of our hospitals today; and that service be provided free, although private health insurance, Medicare, Medicaid and other governmental assistance have diminished both the number of persons needing free care and the hospitals' ability to provide it. Due to the diminishing sources of funds to cover the costs of free care, however, voluntary nonprofit hospitals today cannot satisfactorily meet any required free care needs.

Fortunately, our courts have acted upon the fundamental principle that the law of charity must be responsive to the changing circumstances and the varying needs of the community. In recent years, one court after another has responded to the changing conditions in hospital care and in its method of financing by rejecting the free-care standard as a meaningful criterion for exemption of charitable hospitals.

In rejecting this antiquated standard, the courts have indicated an awareness of the ever increasing federal assistance available to the poor. It is highly pertinent, therefore, to review the various decisions which support the contemporary criteria for charitable hospitals set forth in *Rev. Rul. 69-545* and which firmly establish the principle that the test of a charitable institution "is not the extent of the free services rendered, nor whether the patients pay more or less than cost for the services, but whether those who operate it are doing so for private profit, directly or in-

directly."[86]

An early case containing a realistic response to some of the changing factors discussed above, i.e., an increase in the percentage of expenses covered by patient revenues compared to charitable contributions and the substantial increase in the cost of hospital care, is *Southern Methodist Hospital and Sanitarium v. Wilson,* 51 Ariz. 424, 77 P.2d 458, 461-62 (1938):

> "If, therefore, we are to insist that those who contribute with the idea that the institution which receives their funds is a charitable one, must make that contribution large enough to maintain the institution not only a charitable, but as a free one, in many, if not most, of our communities, there will be no place where the sick may be cared for under any circumstances, except the private nursing homes available only to the very wealthy, or the county hospitals for indigents."

The evolution of the law away from the free-care standard also was described in *Young Men's Christian Ass'n v. Lancaster County,* 106 Neb. 105, 182 N.W. 593 (1921), quoted with approval in *Evangelical Lutheran Good Samaritan Society v. County of Gage,* 181 Neb. 831, 151 N.W.2d 446, 449 (1967):

> "Formerly all institutions furnishing services of this nature, including both hospitals and nursing homes, were providing care for many patients without compensation and extended charity in the sense of alms giving or free services to the poor. With the advent of present-day Social Security and welfare programs, this type of charity is not often found because assistance is available to the poor under these programs. Yet . . . courts have defined 'charity' to be something more than merely alms giving or the relief of poverty and distress and have given it a significance broad enough to include practical enterprise at a good of

[86] HAYT, HAYT, & GROESCHEL, LAW OF HOSPITAL, PHYSICIAN AND PATIENT 68 (2d ed. 1952).

> humanity operated to the moderate cost to those who receive the benefits."[87]

More recently, further doubt has been cast upon the relevance of free care as a standard for charitable exemption:

> "Although 'percentages' may in some future case be controlling, total reliance on the same continues to become more questionable; because the advent of modern day social legislation has resulted in more plans to provide more citizens with assistance in paying for hospital care." *Jackson County v. State County Commissioner,* 521 S.W.2d 378, 384 (Mo. 1975).

Part of the reason for the judicial rejection of the free-care standard has been the recognition by the courts of the increasing reduction in patients needing free care because of the spread of social welfare legislation providing reimbursement for services rendered to them.[88] In *Miami Retreat Foundation v. Ervin,* 62 So. 2d 748 (Fla. 1952) it was alleged that the amount of charity work done was inconsequential and that exemption should be denied. Never-

[87] *Accord,* Evangelical Lutheran Good Samaritan Soc. v. Bd. of County Comm'rs, 219 N.W.2d 900 (N.D. 1974). Despite plaintiffs' attempts to distinguish this case as a matter of local law, one unbiased commentator had stated:

> "The decision in *Evangelical Lutheran* represents the law in the majority of American jurisdictions. In a recent decision rendered in Louisiana [Ruston Hosp., Inc. v. Riser, 191 So. 2d 665 (La. App. 1966)] the court observed that there is an increasing antithetical trend. A study of cases decided during the last ten years does not support this contention." Casenote, *Taxation—Charitable Exemptions From Real Estate Taxes—What is a Charity,* 17 DEPAUL L. REV. 433, 438 (1968) (footnotes omitted).

[88] "Moreover, it is a matter of wide knowledge in which we gladly participate that the public or general welfare policy of Pennsylvania has been increasingly broadened to include greater and greater concern for the aged and the sick and the infirm, and consequently the words 'charity' and 'public charity' must be given a liberal interpretation." *In re* United Presbyterian Homes, 428 Pa. 145, 236 A.2d 776, 779 (1968).

theless, the shift from indigent care to reimbursement was acknowledged and the organization held to be charitable.

> "[M]ost of the persons who would in the normal course of events be admitted as charity patients are accommodated as County patients, and such accommodations paid for by the county. True, they are not received as charity patients, and as a matter of fact, are the chief source of revenue and profit of the Corporation. But in a large measure this accounts for the failure of charity patients to present themselves for admission." *Id.* at 752.[89]

In the light of expanding social welfare programs and the decline in the number of persons for whom reimbursement is not available, our courts have increased their criticism of basing charitable exemption on free care. This is especially true due to the administrative difficulties in applying any free-care standard.

> "A tax exemption cannot depend on any such vague and illusory concept as the percentage of free service actually rendered. This would produce chaotic uncertainty and infinite confusion, permitting a hodgepodge of views on that subject." *City of Richmond v.*

[89] Similarly, in *Evangelical Lutheran Good Samaritan Soc. v. Bd. of County Comm'rs*, 219 N.W.2d 900, 908 (N.D. 1974), the Supreme Court of North Dakota stated:

> "In earlier years, before the advent of modern welfare programs, many persons sought free care from institutions such as those the Society maintains. However, today welfare programs are widespread and a matter of right."

The Supreme Court of Vermont has observed:

> "It may well be that under present and future economic conditions, social welfare programs, or other benefits, few, if any persons residing in Bennington County, or elsewhere, could be considered destitute." Destitute of Bennington County v. Henry W. Putman Mem'l Hosp., 135 Vt. 289, 215 A.2d 134, 142 (1965).

In another recent case decided by the Supreme Court of Arkansas, although the tax assessor argued that "only three charity patients have been treated at the hospital," the hospital

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Richmond Mem'l Hosp., 202 Va. 86, 116 S.E.2d 79, 81-82 (1960).[90]

To avoid the administrative uncertainty and confusion in applying a free care standard, such as contained in *Rev. Rul. 56-185*, our courts have accepted the rule that "without doing any free work of any kind, [a] hospital would still be a charitable corporation so long as the surplus income is applied to the support, maintenance and enlargement of the hospital and its facilities." *Weiss v. Swedish Hospital*, 16 Wash. 2d 446, 133 P.2d 978, 980 (1943); *In re Henderson's Est.*, 17 Cal. 2d 853, 112 P.2d 605, 608 (1941); *City of Richmond v. Richmond Mem'l Hosp.*, 202 Va. 86, 116 S.E.2d 79, 84 (1960).[91] Health law

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had admitted approximately 2,000 patients under Medicare, as well as providing services under Medicaid. Despite the negligible number of patients traditionally regarded as charitable, the hospital was held to be exempt from property taxes as a charitable institution. The court noted that "there would have been a great many more purely public charity cases, had it not been for Medicare payments." Burgess v. Four States Mem'l Hosp., 250 Ark. 485, 465 S.W.2d 693, 697 (1971).

[90] *Accord*, Southern Methodist Hospital and Sanitarium v. Wilson, 51 Ariz. 424, 77 P.2d 458, 462 (1938). "[T]he position that the test of a charitable institution is the extent of the free services rendered, is difficult of application and unsound in theory."

> [91] "[W]e think the institution is properly characterized as a charitable one, notwithstanding the fact that it charges for most, *if not all*, of the services which it may render, so long as its receipts are devoted to the necessary maintenance of the institution and the carrying out of the purpose for which it was organized." *Id.* (emphasis supplied), quoted with approval in Benton County v. Allen, 170 Ore. 481, 133 P.2d 991, 994-95 (1943).
>
> "Whether these hospitals are 'conducted not for profit, but exclusively as charities,' within the meaning of the constitutional provision, depends not upon the number of patients who were treated free of charge, but the nature of the institutions and the purpose of their operations." City of Richmond v. Richmond Mem'l Hosp., 202 Va. 86, 116 S.E.2d 79, 82 (1960).

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treatises reflect a similar view of the present state of the law:

> "To say that the test of a charitable hospital is the amount of free service rendered is to apply a standard which is impractical and unsound . . . Free service is not a prerequisite to tax exemption and the legal meaning of charitable purposes not limited to the care of the indigent." HAYT, HAYT, & GROESCHEL, LAW OF HOSPITAL, PHYSICIAN AND PATIENT 68 (2d ed. 1952); *Accord*, HOSPITAL LAW MANUAL, *Taxation-State* I: 25 (1973).

In the face of these decisions, which comprise the general law of charity in the United States today under which section 501(c)(3) must be interpreted, the Commissioner cannot be said to have been acting outside the scope of his authority in publishing a revenue ruling which modified an earlier requirement for the rendition of free or below-cost care. *Rev. Rul. 69-545* properly reflects the widespread changes in the law of charity brought about by social, economic and technological changes over the past number of years.

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The court further noted that:

> "There is no wording in [the statute] requiring free care or free service. The phrase 'exclusively as charities' describes the institutions entitled to exemption. It does not designate whether the services rendered by them shall be free to the recipients. If the framers of the Constitution had so intended it would have been easy and natural to have specified the rendering of free service as the basis for the exemption." *Id.*

The court then stated:

> "The legal interpretation of the phrase 'not for profit, but exclusively as charities,' is not controlled by free service to the indigent or poor. Nonprofit hospitals which are devoted to the care of the sick, which aid in maintaining public health, and contribute to the advancement of medical science, are and should be regarded as charities." *Id.* at 84.

III. REV. RUL. 69-545 IS CONSISTENT WITH FEDERAL CASE LAW PERTAINING TO TAX EXEMPTION OF NONPROFIT HOSPITALS.

A. Federal Case Law Adjudicating Exempt Status of Nonprofit Hospitals Has Been Directed Toward the Question of the Presence or Absence of Private Benefit Rather Than the Amount of Free Care.

A fundamental principle in charitable trust law is that in order to qualify as charitable, an organization must not only operate in furtherance of charitable purposes, but must also be free of any private benefit.[92] With respect to hospitals, "[t]he test [for tax exemption] is not whether the patients of the hospital pay more or less for their services, but whether those charged with its operations were conducting it for their private profit or advantage."[93]

Rev. Rul. 69-545 sets forth standards which are consistent with the body of law developed from this principle. In asserting that "[e]very Federal tax case has considered service to persons unable to pay as a *sine qua non* of 'charitable' status for nonprofit hospitals,"[94] plaintiffs have misstated the law and have ignored the plain meaning of *Rev. Rul. 69-545* which is consistent with that body of law.

The presence or absence of free care (or the amount of free care rendered) has not been dispositive of a single Federal case. As plaintiffs have indicated,[95] no Federal

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[92] "The controlling feature is whether the institution was built, organized, and/or is maintained with an intent to make a private profit . . . ." State v. Browning, 192 Minn. 25, 255 N.W. 254 (1934). See discussion in Bromberg, *The Charitable Hospital*, 20 CATH. U. L. REV. 237, 251 et seq. (1970).

[93] So. Methodist Hosp. and Sanitarium v. Wilson, 51 Ariz. 424, 77 P.2d 458, 462-63 (1938); Benton County v. Allen, 170 Ore. 481, 133 P.2d 991 (1943); McDonald v. Mass. Gen'l Hosp., 120 Mass. 432. 21 Am. Rep. 529 (1876).

[94] Pl. Br. at 24.

[95] *Id.*

case has ever specifically held that a nonprofit hospital which limited general hospital care exclusively to persons able to pay is charitable. However, it is equally true that no Federal case has ever denied a nonprofit hospital tax exemption under section 501(c)(3) solely on the basis that it did not render free care.[96] Rather, the Federal cases have consistently recognized that all factors must be considered,[97] and they have focused on evidence determining the presence or absence of private benefit or profit.

For example, in *Sonora Community Hospital*, 46 T.C. 519 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968), the founders of the original proprietary institution, which converted to nonprofit status, continued to control the nonprofit organization and diverted a substantial part of the hospital's income to themselves through private arrangements with its departments. The Tax Court found that "the hospital was operated to a considerable extent for the benefit of the founding doctors . . ." and therefore denied exemption.

Similarly, in *Lorain Avenue Clinic*, 31 T.C. 141, 160 (1958), the Tax Court, in denying exemption, found that the clinic "was operated for profit by a small family group; that operations for profit were petitioner's predominant

[96] A careful reading of the Federal cases cited by plaintiffs reveals that the IRS has *never* litigated a case involving a nonprofit hospital where the question of private benefit to the dominant group of physicians, shareholders, or directors was not involved.

[97] Harding Hosp., Inc. v. United States, 505 F.2d 1068, 1077 (6th Cir. 1975):

> "We do not single out any one or combination of these factors as the consideration crucial to our holding. We conclude only that all these factors, as they occurred in the aggregate in this case, require denying the appellant Hospital the tax exemption for the years in question."

Accord, Maynard Hosp., Inc., 52 T.C. 1006, 1030 (1969); Sonora Commun. Hosp., 46 T.C. 519 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968).

activity . . . ." Most recently, in *Harding Hospital, Inc. v. United States*, 505 F.2d 1068 (6th Cir. 1975), the Sixth Circuit denied exemption to a hospital, the operations of which were permeated with evidence of private benefit. Three of the five factors on which the court based its denial of exemption involved evidence that the doctors controlling the hospital were operating it for their private benefit.[98]

In other Federal cases where the Government has attacked a hospital's exemption based upon the existence of private benefit, the presence of free care provided evidence of an absence of private benefit or profit. In the absence of other evidence of private benefit, the hospitals were accordingly held exempt. For example, in *Intercity Hospital Association v. Squire*, 56 F. Supp. 472 (W.D. Wash. 1944), involving the conversion of a profit-making hospital to a nonprofit one, the presence of a liberal rule for the admission of indigent patients enabled the hospital to overcome the Government's contention that there had been no real change in its methods and practices from those of its predecessor, a private profit corporation.[99] Similarly, in

[98] Other Federal cases involving hospitals or clinics whose exemption was denied because of the presence of private benefit are William H. Kenner, 20 CCH TAX CT. MEM. 185 (1961), *aff'd*, 318 F.2d 632 (7th Cir. 1963); Maynard Hosp., Inc., 52 T.C. 1006 (1969); John J. Cranley, Jr., 20 CCH TAX CT. MEM. 20 (1961); *see also* Hassett v. Assoc. Hosp. Serv. Corp., 125 F.2d 611 (1st Cir.), *cert. denied*, 316 U.S. 672 (1942), where the organization was treated as operated for the private benefit of its subscribers and did not make its services available to all persons in the community able to pay.

[99] "Another area of concern which has implications, not only for Medicare and Medicaid, but also for the tax collector, involves a trend toward changing the status of a proprietary health care facility to that of a 'nonprofit' institution." REPORT OF THE STAFF TO THE COMM. ON FINANCE, U.S. SENATE, MEDICARE AND MEDICAID: PROBLEMS, ISSUES AND ALTERNATIVES, 91st Cong., 1st Sess. 140 (1970). This longstanding concern accounts for the thrust of litigation in the Federal courts questioning the tax exempt status of institutions converting from proprietary to nonprofit status because of the continuation of private benefits.

Robert C. Olney, 17 CCH TAX CT. MEM. 982 (1958) and *Davis Hospital, Inc.*, 4 CCH TAX CT. MEM. 312 (1945), a reasonable volume of free care enabled the hospitals to rebut the Government's claim of private benefit.[100]

In none of these cases did denial or affirmance of exemption turn primarily on the issue of free care.[101] Whenever a hospital is operated for private benefit, those controlling it normally try to minimize losses from free care in order to maximize their own private profit. The failure to provide free care in *Sonora, Lorain, Harding* and other Federal cases is merely *further evidence* that the parties controlling the hospital were operating it for their private benefit. The inescapable fact in the *Sonora, Lorain*

[100] In *Commissioner v. Battle Creek, Inc.*, 126 F.2d 405 (5th Cir. 1942), the subject hospital had been organized under the general corporation laws of Florida, rather than under the non-profit corporation laws. Its charter authorized it to conduct any lawful business. The Government argued that the organization did not qualify as being organized exclusively for charitable purposes because of the business powers authorized in its charter. The court rejected this argument and found in favor of the hospital. Furthermore, the absence of provisions dedicating the hospital's assets to charitable purposes in the event of dissolution (the organizational test) was open to attack. Failure to dedicate assets to charity makes the organization susceptible to having its assets ultimately inure to the benefit of private individuals.

The holding of the case thus relates to the organizational test, (Treas. Reg. §1.501(c)(3)-1(b)) rather than the operational test (Treas. Reg. §1.501(c)(3)-1(c)) for exemption under section 501(c)(3). *Rev. Rul. 56-185* acknowledges the proper context of this case by citing it in criteria 1. which deals with the organizational test, rather than in criteria 2. which deals with free care:

> "1. It must be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick. A nonprofit hospital chartered only in general terms as a charitable corporation can meet the test as being organized exclusively for charitable purposes. See *Commissioner v. Battle Creek, Inc.* 126 Fed. (2d) 405." 1956-1 CUM. BULL. 202, 203.

[101] The only case dealing exclusively with the question of whether a tax exempt health institution may charge all persons served is *Salem Lutheran Home Assoc.*, 2 CCH TAX CT. MEM. 157 (1943), in which the tax court held the organization exempt.

and *Harding* cases is that none of those hospitals could have qualified under section 501(c)(3), regardless of the percentage of free care provided, because there was other compelling evidence that they were operated for the private benefit of a small group of physicians.

In *Intercity Hospital, Olney* and *Davis Hospital*, the presence of free care, in the absence of other evidence, rebutted the existence of private benefit or profit which would have resulted in the denial of those hospitals' exemptions. Thus, although it is appropriate to consider free care to determine the presence or absence of private benefit or profit, these cases provide neither precedent nor any meaningful guidelines for cases not involving private benefit or profit.

Even assuming, *arguendo*, that the levels of free care suggested in these cases may be relevant to the question of charitable exemption outside the context of private benefit, they are not applicable under today's conditions. *Battle Creek, Davis Hospital* and *Intercity Hospital* were decided between 1942 and 1945. The free or below cost care involved in these cases, ranging from 6% to 47%,[102] may have had some meaning for particular hospitals 30 years ago. However, in view of the changes previously discussed,[103] particularly the substantial increase in coverage

[102] In *Battle Creek*, 705 of 1,776 clinic patients were treated free and 145 paid a portion of the regular rates. Thus 47% of the patients treated were treated free or below cost. In *Davis Hospital*, the hospital "received no compensation from any source for services rendered to from 30 to 40 per cent of the patients admitted to and treated in its hospital." In *Intercity Hospital Assoc.*, "an amount ranging from six to eight per cent, of such gross income was donated to charity patients." The above figures also illustrate another facet of these earlier Federal decisions. There is such a wide variation in the range of percentages of free care suggested in these cases that no ascertainable standards can be found. As discussed in Section VI, *infra* this is one of the reasons which compelled the Commissioner to issue *Rev. Rul. 69-545* to modify *Rev. Rul. 56-185*.

[103] See Section II, *supra*.

of the population by some form of health insurance, the levels of free care suggested in earlier cases should have no bearing on the Court's consideration of the criteria for exemption of today's hospitals.[104]

In summation, Federal case law dealing with the tax-exempt status of nonprofit hospitals is distinguishable because those cases primarily involve the issue of private benefit, or as in the *Battle Creek* case, the failure to comply with the formalities of the organizational test (which could result in private benefit). In any event the free care analysis extrapolated by plaintiffs from these cases is outmoded. Thus, the language in these cases pertaining to percentage of free care should have no bearing on the issue before the Court.

B. Rev. Rul. 69-545 Follows the Approach Taken in Federal Case Law.

As indicated above, Federal case law requires a consideration of all pertinent factors to determine the exempt status of a nonprofit hospital. The IRS has followed this approach in its revenue rulings. A two-part test, requiring both a charitable purpose and the absence of private benefit or profit, was initially stated in *Rev. Rul. 56-185*, which defined the term "charitable" as contemplating "an implied public trust constituted for some public benefit, the income or beneficial interest of which may not inure

[104] "Hospital expenses per patient day have increased over 700% since 1946, rising especially rapidly the last several years. . . . Among factors contributing to the rise in hospital expenses are technological changes, increased demand, and rising costs of labor and supplies. . . . The public also demands more—a large number of more costly services—from the hospital now than it did two decades ago because of rising income, increasing insurance coverage, and changing demographic characteristics of the population."

BASIC FACTS ON THE HEALTH INDUSTRY, HOUSE COMM. ON WAYS AND MEANS, 91st Cong., 1st Sess. 52 (1971).

to the benefit of any private shareholder or individual."[105]

Rev. Rul. 69-545 continues this two-part test.[106] Although the promotion of health in a manner beneficial to the community is posited as the charitable purpose, guidelines are set forth for situations which involve private benefit. In fact, the discussion in the Ruling of Hospital *B*, which is denied exemption under section 501(c)(3) because of the presence of private benefit, has generally been ignored. It is this very distinction between hospitals operated for the benefit of the public and those operated for private interests, illustrated in *Rev. Rul. 69-545* by Hospitals *A* and *B*, respectively, which has consistently been the gravamen of decisions rendered in Federal cases involving tax exempt hospitals. This concern for both facets of the test of charitable status makes *Rev. Rul. 69-545* consistent with Federal case law.

IV. REV. RUL. 69-545 IS CONSISTENT WITH FEDERAL HEALTH POLICY.

Plaintiffs' contention that "Federal health policy presupposes and requires that nonprofit hospitals provide free care to the indigent" is inaccurate.[107] No such Federal policy exists.

[105] *Rev. Rul. 56-185* places strong emphasis on the "private benefit" problem in its third and fourth criteria. It also states that "a hospital formed by one or more physicians in a community who may own the capital stock thereof or rent the hospital facilities to a corporation which they control requires careful study to determine whether it is being operated in part to serve their interest, directly or indirectly." 1956-1 CUM. BULL. 202, 204.

[106] "These factors indicate that the use and control of Hospital *A* are for the benefit of the public and that no part of the income of the organization is inuring to the benefit of any private individual nor is any private interest being served." 1969-2 CUM. BULL. 117, 118.

[107] Pl. Br. at 38.

The Federal government has long recognized the importance of adequate health care for all. However, Federal policy is directed towards achieving this goal by providing reimbursement for health services for persons unable to pay, rather than by imposing an obligation upon health care providers to supply free care.[108] Medicare and Medicaid, 42 U.S.C. §1395-1396, provide the clearest and most significant expression of this Federal policy of upgrading the health care of all citizens by providing the suppliers of such care with reimbursement from federal, state and private sources.

The various legislative proposals for national health insurance introduced during the 93rd and 94th Congress further illustrate the Federal reimbursement policy. None of these bills contain any obligation on the part of hospitals to provide free care. They do, however, recognize that the Federal government should guarantee adequate health care for all by assuming the cost of hospital insurance for those unable to pay.[109]

As evidence of an alleged Federal free-care policy, plaintiffs refer to the obligation to provide indigent care imposed upon recipients of construction grants under the Hill-Burton Program and its successor, the National Health

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[108] "The American tradition has been to make hospitals as nearly self-supporting as possible, and the present trend seems to be to make governmental aid to hospitals available on the basis of individual patient service for those who cannot pay, in order to preserve the practice which has been so effective in the development of a superior hospital service." COMM'N ON HOSPITAL CARE, HOSPITAL CARE IN THE UNITED STATES 537-39 (1947).

[109] See the major proposals introduced during the 93rd and 94th Congress: H.R. 1, 94th Cong., 1st Sess. (1975) (The Ullman Bill); S. 3, 94th Cong., 1st Sess. (1975) (The Kennedy-Griffiths Bill); S. 33286/H.R. 3870, 93rd Cong., 2nd Sess. (1974) (The Kennedy-Mills Bill); S. 44/H.R. 2222 (Hansen-Broyhill-Fulton Bill); S. 2513, 93rd Cong., 2nd Sess. (1974) (Long-Ribicoff Bill); and H.R. 12684/S. 2970, 93rd Cong., 2nd Sess. (1974) (Mills, Schneebeli-Packwood Bill).

Planning and Resources Development Act of 1974, 42 U.S.C. 291 *et seq.* (collectively referred to as the "Hill-Burton Program"). Rather than being evidence of a Federal free-care policy, however, the Hill-Burton Program is actually a further example of Federal reimbursement policy. As under Medicare and Medicaid, the Federal government is really purchasing services for the poor, although under the Hill-Burton Program payments are made in advance of, rather than subsequent to, the rendition of services.[110]

In any event, grants made under the Hill-Burton Program represent only a small part of the government's overall health program. A comparison of (a) government expenditures for reimbursement to health care providers under Medicare and Medicaid to (b) amounts expended under the Hill-Burton Program evidences an overwhelming commitment to a Federal reimbursement policy. For example, in 1974 the Federal government spent 125 times more on reimbursement for health services than it spent on grants under the Hill-Burton Program.[111]

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[110] This obligation to provide a reasonable volume of services to persons unable to pay has been held to be a contractual obligation arising out of the receipt of Federal funds under the Hill-Burton Program. *E.g.*, Euresti v. Stenner, 458 F.2d 1115 (10th Cir. 1972); Corum v. Beth Israel Medical Ctr., 359 F. Supp. 909, 912 (S.D. N.Y. 1973).

[111] In 1974 the Government spent $11,321,900,000 on Medicare payments and $11,218,400,000 on Medicaid payments for a total expenditure of $22,545,300,000. Worthington, *National Health Expenditures, 1929-1974*, 38 SOC. SEC. BULL. 3, at 10 Table 3 (Feb. 1975). On the other hand, government appropriation for health facilities construction under the Hill-Burton Program during 1974 was only $120,000,000. U. S. DEPT. OF HEW, PUBLIC HEALTH SERVICES, HEALTH FACILITIES CONSTRUCTION: BY TYPE OF FUNDS (1920-1974) (HILL-BURTON FEDERAL GRANTS).

V. REV. RUL. 69-545 IS CONSISTENT WITH THE LEGISLATIVE HISTORY OF SECTION 501(c)(3)

The Revenue Act of 1894 (Act of Aug. 15, 1894, ch. 349, 28 Stat. 553) was the first Federal act to impose a tax on the income and profits of corporations generally. The Act also contained the first exemption provision, the language of which has generally been used in every subsequent income tax law:

> "That nothing herein contained shall apply to . . . corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes, . . . " Act of Aug. 15, 1894, ch. 349, §32, 28 Stat. 553, 556.

This exemption provision was enacted without debate and virtually without comment. Congressman Tucker, in offering the amendment providing for the exemption, stated merely that it was intended to assure that "educational and charitable institutions may not suffer under the bill."[112]

The income tax of 1894 was declared unconstitutional,[113] but in 1909 Congress enacted an excise tax upon corporate income which carried over the substance of the 1894 exemption provision. Act of August 5, 1909, ch. 6, §38, 36 Stat. 11, 113. This exemption, introduced by Senator Bacon, exempted from tax those associations

> "organized and operated for religious, charitable or educational purposes, no part of the profit of which inures to the benefit of any private stockholder or individual, but all of the profit of which is in good faith devoted to the said religious, charitable, or educational purposes." 44 Cong. Rec. 4151 (1909).

The only meaningful discussion of the 1909 exemption was offered by Senator Bacon during the Senate debate:

> "It occurred to me that in this partial levy of tax, where we are seeking to reach a certain class of wealth, we very properly except those institutions and those enterprises which have no element of personal gain in them whatever, and which are devoted exclusively *to the relief of suffering, to the alleviation of our people, and to all things which commend themselves to every charitable and just impulse.*" 44 Cong. Rec. 4150 (emphasis supplied).

This language does not indicate any attempt to limit the charitable exemption to organizations relieving poverty, but rather points to the broader "humanitarian approach" which recognizes the social benefits attendant to all forms of relief of distress upon which charitable exemptions in general, and *Rev. Rul. 69-545* in particular, are based.

In 1913 the Constitution was amended and Congress re-established the income tax in the Act of October 3, 1913, ch. 16, 38 Stat. 114, carrying over the exemption provisions of the corporation excise tax of 1909. *Id.* at §II.G.(a), 38 Stat. 114, 172.

The first legislative history specifically relevant to income tax exemption of hospitals is found in connection with the interpretation of an analogous section of the Social Security Act of 1935, when an amendment was proposed to add hospitals to the class of exempt organizations "organized and operated exclusively for . . . charitable . . . purposes" under that Act. Section 210(b)(7) of the Social Security Act.[114] The Statement of the Managers on this amendment illustrates Congress' recognition that the term "charitable" in section 501(c)(3) includes nonprofit hospitals.

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[112] 26 Cong. Rec. 1727 (1894).

[113] Pollack v. Farmers' Loan & Trust Co., 157 U.S. 429, *aff'd on reh.*, 158 U.S. 601 (1895).

[114] Social Security Act, Title II, ch. 531, §210(b)(7), 49 Stat. 620, 625 (Aug. 14, 1935), as amended, Social Security Act Amendments of 1939, Title II, ch. 666, §209(b)(8), 53 Stat. 1360, 1374 (Aug. 10, 1939).

> "The Senate amendment adds to the list of purposes 'or hospital' as a clarifying amendment. The Senate recedes, the conferees omitting this language as surplusage, based on the fact that the Internal Revenue Bureau has uniformly construed language in the income tax laws, identical with that found in the House bill, as exempting hospitals not operated for profit, and also on the fear that the insertion of the words added by the Senate amendment might interfere with the continuation of the long-continued construction of the income tax law." H.R. REP. No. 1540, 74th Cong., 1st Sess. 7 (1935).[115]

Plaintiffs, however, refer to two other instances of Congressional inaction as alleged support for their position that nonprofit hospitals must relieve poverty as a condition of their charitable status under section 501(c)(3). The first relates to a 1924 Senatorial consideration of an amendment to section 214(a)(11) of the Revenue Acts of 1918 and 1921,[116] which was the predecessor of section 170(c)(2)(B) and which had purportedly been interpreted in I.T. 1800[117] Pl. Br. at 25.

In I.T. 1800 the Commissioner appeared to reject various legal definitions of the term "charitable" in favor of the position that the term "charitable" should be used in its popular and ordinary sense which allegedly pertained to the relief of poverty.[118] The proposed amendment was to define "charitable" purposes in section 214(a)(11) to in-

[115] Providing further support, the Attorney General of the United States has stated that "the history clearly shows that the language of the [charitable] exemption in the [Social Security] statute was adopted by Congress with knowledge that it has been construed to include nonprofit hospitals." 40 OP. ATT'Y GEN. 286 (1947).

[116] Rev. Act of 1918, ch. 18, 40 Stat. 1057 (Feb. 24, 1919); Rev. Act of 1921, ch. 136, 42 Stat. 227, 241 (Nov. 23, 1921).

[117] I.T. 1800, II-2 CUM. BULL. 152 (1923).

[118] *Id.* at 153; see also the discussion of the lack of legal validity of the separateness theory, Reiling, *Federal Taxation: What Is a Charitable Organization?*, 44 A.B.A.J. 525, 527-28 (1958).

clude "preventive and constructive service for relief, rehabilitation, health, character building, and citizenship" purposes.[119]

Plaintiffs attempt to infer a Congressional intent to require hospitals to relieve poverty as a condition to charitable status from the subsequent abandonment of this proposal on the Senate floor. Such an inference is without support for two reasons. First, the "relief of poverty" interpretation *by the Commissioner* apparently contained in I.T. 1800 has long since been rejected and obsoleted,[120] and I.T. 1800 was specifically overruled by Income Tax Regulation §1.501(c)(3)-1(d)(2).[121] This simply illustrates that the Commissioner has the unquestioned authority to change his interpretation and still adhere to the intent of section 501(c)(3).[122]

Secondly, as Senator Willis specifically stated, the amendment was introduced "in order to draw the attention of the Senate to the dangerous situation in which the *community-chest funds* will be if the bill shall pass in its present form."[123] Since its specific purpose was to permit community-chest funds to operate for the purpose enumerated in the proposed amendment, its subsequent abandonment by Congress is meaningless as evidence of any Congressional intent with respect to the tax-exempt status of nonprofit hospitals.

The other instance of legislative inaction asserted by plaintiffs as supporting their position involved the elimi-

[119] 65 Cong. Rec. 8171 (1924).

[120] Declared obsolete in Rev. Rul. 69-43, 1969-1 CUM. BULL. 310, *modified in* S.M. 2160, III-2 CUM. BULL. 151 (1924). Sol. Op. 159, III-1 CUM. BULL. 480 (1924); *see also* Isabel Peters, 21 T.C. 55 (1953), *acquiescence in* Rev. Rul. 59-310, 1959-2 CUM. BULL. 146.

[121] T.D. 6391, 24 Fed. Reg. 5217 (1959).

[122] Section 7805 of the Code.

[123] 65 Cong. Rec. 8171 (1924) (emphasis supplied).

nation of a proposal from the Tax Reform Act of 1969 to specifically exempt under section 501(c)(3) organizations organized and operated exclusively for providing hospital care. Pl. Br. at 25-28. The initial Bill, H.R. 13270, as reported out of the House, provided for the exemption of organizations which are "organized and operated exclusively for the providing of hospital care."[124] The principal reason for this proposal was the "significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status," and the proposal was designed to remove "such uncertainty by establishing hospitals as a separate exempt category. . . ."[125]

Prior to consideration of H.R. 13270 in the Senate, the Senate Committee on Finance instructed its staff to summarize the various provisions in the Bill and to describe the major arguments for and against the House amendments to the Bill.[126] One argument in the summary against the Bill was:

> "(7) Since the need for new legislative language has arisen because of uncertainties in administration, then the resolution of such uncertainties could be handled on an administrative basis."[127]

Thereafter, apparently in response to the suggestion in this argument, the IRS promulgated *Rev. Rul. 69-545* which set forth more administrable standards for exemption of nonprofit hospitals. Since *Rev. Rul. 69-545* eliminated any uncertainty with respect to the administrative

[124] H.R. 13270, §§101(j) and 201(a), 91st Cong., 1st Sess. (1969).

[125] H.R. Rep. No. 91-413 (Part I), 91st Cong., 1st Sess. 43 (1969).

[126] Report of the Staff of the Comm. on Fin., Medicare and Medicaid: Problems, Issues and Alternatives, 91st Cong., 1st Sess. 55 (1970).

[127] Summary of H.R. 13270, The Tax Reform Act of 1969 (as passed by the House of Representatives), 91st Cong., 1st Sess. 24 (1969).

standards applied under former Rulings, the need for remedial legislation had become moot.[128] The Senate Finance Committee then deleted the hospital exemption from H.R. 13270.

Contrary to plaintiffs' argument, the language in the Senate Report[129] does not indicate a Congressional opinion that *Rev. Rul. 69-545* was contrary to the charitable provisions of section 501(c)(3). It is not possible to tell from the language in the Report whether the Committee, after the suggestion of its own staff that this matter be handled administratively, acted because it thought the hospital care amendment was unnecessary, in view of the publication of *Rev. Rul. 69-545*, or was undesirable.

Under such circumstances, "the failure of Congress to amend the statute is without meaning for purposes of statutory interpretation." *Order of Ry. Conductors v. Swan*, 329 U.S. 520, 529 (1947). Congressional silence is almost always a weak and hazardous basis for interpretation.[130] This is especially true since the term "charitable," as used in section 501(c)(3), is required to be defined in accordance with its generally accepted legal sense as developed by judicial decisions. As the courts have observed "[when] a statute is subjected to the interpretation of the courts, too much weight should not be given to the language contained in discarded meas-

[128] It is noted that although *Rev. Rul. 69-545* contained narrower standards, i.e., open emergency room, care of Medicare and Medicaid patients, publicly controlled governing body, absence of private benefit etc., than originally contemplated under the legislation proposed by the House, it nevertheless offered a set of definite and administrative standards that both the hospitals and IRS could follow. For this reason, the need for the proposed remedial legislation became moot.

[129] S. Rep. No. 91-552, 91st Cong., 1st Sess. 61 (1969).

[130] American Trucking v. A.T. & S.F.R.R., 387 U.S. 397, 417-18 (1967); Red Lion Broadcasting Co. v. F.C.C., 395 U.S. 367, 382 n. 11 (1969); Zuber v. Allen, 396 U.S. 168 (1969).

ures or to the statements of legislators in the course of debate."[131]

VI. THE ISSUANCE OF REV. RUL. 69-545 WAS REQUIRED BY THE AMENDED 1959 TREASURY REGULATIONS AND BY RELEVANT ADMINISTRATIVE CONSIDERATIONS.

A. Treasury Regulations Promulgated in 1959 Recognized Broad Concepts of Charity and Required Revision of Rev. Rul. 56-185.

Following the enactment of the new Internal Revenue Code of 1954, the Treasury Department undertook to issue new regulations under section 501(c)(3). The regulations, in effect at the time *Rev. Rul. 56-185* was issued, defined "charitable purposes" as follows:

> "Corporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor." Treas. Reg. 118, §39.101(6)-1(b) (1953).

Proposed regulations, initially issued in 1956,[132] basically repeated this restrictive view of charity, but were withdrawn while a more thorough study was made. The first comprehensive set of regulations interpreting section 501(c)(3) were proposed early in 1959[133] and, after a public hearing, "final" regulations were issued in 1959.[134]

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[131] Jefferson v. United States, 178 F.2d 518, 520 (4th Cir. 1949), *aff'd sub nom.* Feres v. United States, 340 U.S. 135 (1950).

[132] 21 Fed. Reg. 460 (1956).

[133] 24 Fed. Reg. 1431 (1959).

[134] T.D. 6391, 24 Fed. Reg. 5217 (1959). The regulations proposed in 1956 indicated that the fact "that a hospital may require payments for services from those able to pay, will not necessarily preclude exemption." Proposed Treas. Reg. §1.501(c)(3)-1(b), 21 Fed. Reg. 460, 464 (1956). Although these proposed regulations were subsequently withdrawn in favor of

(Footnote continued on following page)

The key provision of the regulations, §1.501(c)(3)-1(d)(2), reads as follows:

> "(2) *Charitable defined.* The term 'charitable' is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decisions. Such term includes: relief of the poor and distressed or of the underprivileged; advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human and civil rights secured by law; or (iv) to combat community deterioration and juvenile delinquency."

These regulations recognize that the term "charity" is not limited to "relief of poverty," but encompasses a broad concept of community benefit or public interest as discussed in Section I above. Accordingly, the Commissioner was required to re-examine *Rev. Rul. 56-185* issued three years earlier under the prior regulations because the relief of poverty requirement in *Rev. Rul. 56-185* was inconsistent with the 1959 regulations.[135] Thus, the issu-

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the even broader view of charity expressed in the 1959 regulations, Treas. Reg. §1.501(c)(3)-1(d)(2), the public was put on notice of a shift in the attitude of the IRS toward a more liberal view of tax exemption of nonprofit hospitals and was afforded an opportunity to comment on this subject.

[135] In issuing interpretative rulings under section 501(c)(3), the Commissioner was bound to consider the rule construction in *Helvering v. Bliss*, 293 U.S. 143, 150-51 (1934) that the "exemption of income devoted to charity and the reduction of the rate of tax on capital gains were liberalizations of the taxpayer's favor, were begotten from motives of public policy, and are not to be narrowly construed."

ance of *Rev. Rul.* 69-545 was not an arbitrary act by the Commissioner; it was compelled by law and regulations, with adequate opportunity for public comment and hearings.[136]

B. Modification of Rev. Rul. 56-185 Was Required for Sound Administrative Reasons.

Rev. Rul. 56-185 contained serious administrative inadequacies which necessitated amendment. In the first place, the Ruling is confusing and internally inconsistent. Although primarily relying on relief of poverty, *Rev. Rul. 56-185* also admits of other broader grounds for exemption of nonprofit hospitals. It states that a hospital may be exempt under section 501(c)(3) because it is "organized and operated primarily for educational, scientific, *or* public charitable purposes," indicating a recognition that there are other reasons for exempting a hospital besides its ability to render free care. Thus, under the 1956 Ruling, nonprofit hospitals could be exempt by conducting medical education, training or research, thereby benefiting mankind even though they may be unable to provide free care. Such confusion created difficulties in its application and led to challenges and uneven administration.

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[136] It should be especially noted that the regulations promulgated in 1959 resulted from a prolonged study within the Treasury Department of the existing law, views reflected in written comments, and public hearings on the proposed regulations. The opportunity for public hearing on the proposed regulations afforded all persons concerned an opportunity to express to the appropriate adminstrative officers their views on the same issues now before the Court because once the regulations, embodying the broad definition of the law of charity, were proposed, *Rev. Rul. 56-185* with its narrow view of charity was brought into question. After the regulations were finalized, the Commissioner was required to revise and change the relief of poverty requirement as a *sine qua non* to exemption in *Rev. Rul. 56-185* to conform with the new regulations.

Second, the test set forth in the 1956 Ruling for operating in furtherance of "public charitable" purposes (as opposed to "educational" or "scientific" purposes) is itself difficult to administer. This test requires an exempt hospital to operate "to the extent of its financial ability for those unable to pay," and the difficulty in administering this test is highlighted by the number of significant internal modifications in the Ruling.[137]

For example, although many hospitals realize an annual surplus or "profit" for accounting purposes, such superficial appearance of "financial ability" to provide indigent care can be illusory because such accounting is unrelated to cash needs for such matters as debt service.[138] Hospitals with a more favorable cash flow may need those funds for renovation or modernization of obsolescent facilities, the purchase of new equipment, or to implement

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[137] *Rev. Rul. 56-185* modifies the "financial ability" standard as follows:

> "The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. . . . It may also set aside earnings which it uses for improvements and additions to hospital facilities.
>
> . . .
>
> "A nominal charity record for a given period of time, in the absence of charitable demands of the community, will not affect its right to continued exemption." 1956-1 CUM. BULL. 203-04.

The lack of any clear standards generated controversies similar to those found in ad valorem litigation, such as whether bad debts, unreimbursed portions of the cost of caring for Medicaid patients, and Medicare losses and disallowances constitute "charity" or "free care." *See* Jackson County v. State Tax Comm'r, 521 S.W.2d 378, 384 (Mo. 1975); *AHA Statement*, HEARINGS ON H.R. 13270 BEFORE HOUSE COMM. ON WAYS AND MEANS, 91st Cong., 1st Sess. (1969).

[138] "[The hospital] utilizes any profits for purposes that will better enable it to function as a hospital and nurses' training school. This is because profits are used for debt retirement, plant expansion, and modernization of facilities. . . . " Duncan v. Steeper, 17 Wisc. 2d 226, 235, 116 N.W.2d 154, 158 (1962).

new medical procedures or training programs.[139] Many existing facilities have serious deficiencies in terms of patient and personnel safety, functional adequacy, overall quality and accessibility, which result in a constant demand for capital to remedy these problems.[140]

Because of these competing demands on hospital funds, the financial ability test of *Rev. Rul. 56-185* pits the judgment of revenue agents against those of hospital administrators, boards of trustees, and local health planning agencies as to the allocation of funds between indigent care and all other community priorities.[141]

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[139] Capital needs of hospitals today have shifted from construction of new hospitals to renovation and modernization of existing facilities. "The primary [reason] is the inevitable obsolescence of facilities. Advances in medical science demand development of more sophisticated accommodations, such as intensive care and/or cardiac care units. Evolutions in the patterns of care demand less sophisticated facilities, such as extended care beds and enlarged or renovated ambulatory care departments. Technological advances in the ancillary services also required that these departments be brought up to date." Editorial Note, *Renovation Projects Swell Total Hospital Construction*, 48 HOSPITALS 51 (Feb. 1, 1974).

[140] "[B]ecause of technological and physical obsolescence, there is substantial expense in simply staying even." Pierson, *An Examination of Obsolescence*, 48 HOSPITALS 52 (Feb. 1, 1974).

[141] If plaintiffs' position of free care were adopted, the total financial burden on hospitals, in exchange for tax exemption under section 501(c)(3), would be enormous. As Professor Cantor points out, this raises the question of whether such a burden would constitute an unconstitutional taking within the purview of the Fifth Amendment.

> "Yet fiscal integrity remains an important consideration in determining whether a hospital should be compelled to service indigent patients. The economic burden might be great enough to invoke complaints of an unconstitutional 'taking'; at the very least, the expense would have a substantial enough impact on a hospital's ability to function to warrant careful consideration. These factors assume even greater importance when it is considered that hospitals, unlike governmental bodies, do not possess the taxing power necescary to distribute 'public interest' burdens over the general population. Thus, unless third-party payments from private

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In an article arguing for the imposition of a common law right of access by the poor to health care, Professor Cantor acknowledged, in a realistic fashion, the type of problems that both hospitals and revenue officials faced in attempting to function under *Rev. Rul. 56-185*. Although lengthy, the following excerpt illustrates these problems:

> "[T]here are several reasons why the threat to fiscal integrity from a common law right of access cannot be ignored. In the first place, even if reallocation of internal resources rather than insolvency would be the product of the proposed common law obligation, courts must be hesitant to mandate that result. There is no assurance that resources for patient care would not be diverted from *needed* expansion or *necessary* research. Arguably, '[h]ospitals should to a great extent be free to allocate their money according to a scheme which they in good faith believe will produce the greatest good for the greatest number of patients.' Nor can it be automatically assumed that government would fully subsidize the research and teaching potentially affected by added patient care obligations. Second, the added fiscal burden imposed by a common law right of access would probably cripple, and not just hamper, some hospitals. An urban institution which services a primarily poor population would not have the needed budgetary flexibility to absorb the burden of indigents' care. Without a comprehensive system of third-party payments—a system which Medicaid and Medicare do not yet provide—insolvency would presumably result. These various administrative problems

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insurers or government benefit programs covered all patients, a situation which clearly does not exist, the fiscal burdens on private hospitals stemming from indigents' care would be a very real factor to consider in shaping any emerging common law obligation . . . . " Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901, 916 (1970).

> and issues indica[illegible] that courts would have to struggle to monitor a standard which varied the obligation of hospitals toward indigent patients according to the economic viability of particular institutions. Yet imposition of a crippling financial burden might be both unwise and constitutionally suspect.[142]

Rev. Rul. 56-185 was therefore inadequate in failing to provide realistic and ascertainable standards for administration. Its imprecise standards "resulted in significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status."[143] The correction of these inadequacies by the publication of *Rev. Rul. 69-545* was required as a matter of sound administration and fair treatment of the institution involved. Such needed corrective action was not an abuse of discretion by the Commissioner.

C. The Requirements of Rev. Rul. 69-545 for Providing Emergency Care and Treating Medicare and Medicaid Patients Provide a Valid Administrative Alternative to Prior Requirements for Free Care for the Poor.

As discussed above, *Rev. Rul. 69-545* was required to correct the administrative deficiencies of *Rev. Rul. 56-185*. However, the implication advanced by plaintiffs and the

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[142] *Id.* at 916-18 (emphasis in original) cited in Mem'l Hosp. v. Maricopa County, 415 U.S. 250, 264 n. 23 (1974). In a similar vein another commentator has noted:

> "It may also be unreasonable to expect hospitals to 'pay' the cost of satisfying the public conscience by diverting its funds from other treatment programs. Hospitals should to a great extent be free to allocate their money according to a scheme which they in good faith believe will produce the greatest good for the greatest number of patients." Note, *Scarce Medical Resources*, 69 COLUM. L. REV. 620, 691 (1969).

[143] H.R. REP. No. 91-413 (Part 1), 91st Cong., 1st Sess. 23 (1969). See also the reference to this "indefinite test of to what extent the hospital must serve those who cannot pay" in the SUMMARY OF H.R. 13270, HOUSE COMM. ON WAYS AND MEANS, 91st Cong., 1st Sess. 23 (1969).

District Court below that *Rev. Rul. 69-545* has removed any obligation on the part of charitable hospitals to provide "special financial consideration" for the poor is inaccurate.

Rev. Rul. 69-545 does, in fact, provide a realistic and meaningful way by which an exempt hospital can continue to satisfy such obligations.

> "By operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement [such as with the aid of public programs like Medicare and Medicaid], Hospital *A* is promoting the health of a class of persons that is broad enough to benefit the community."

Because of these two conditions, *Rev. Rul. 69-545* imposes an obligation on exempt hospitals for the benefit of the poor which is more significant than the highly subjective "financial ability" standard of *Rev. Rul. 56-185*.[144]

1. The Emergency Room Is the Most Important Means of Access to Medical Care for the Poor.

Plaintiffs have attempted to minimize the significance of the requirement that exemption under *Rev. Rul. 69-545* requires the operation of an emergency room open to all persons regardless of ability to pay.[145] However, the imposition of this requirement is a positive contribution by the IRS to insure health care for indigents when most needed.

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[144] In this context, the Court should take notice of the fact that the provisions of emergency care and treatment of patients covered by public programs, such as Medicare and Medicaid, as criteria for determining exemption under section 501(c)(3) were spelled out in *Rev. Rul. 69-545 for the first time* and despite their importance to the provision of hospital care for the poor, were not factors considered under earlier rulings.

[145] The losses generated by most emergency rooms may have encouraged some hospitals to limit the scope of this activity. *Rev. Rul. 69-545* provides an important safeguard against this.

As indicated by Professor Cantor, "it becomes all the more important to guarantee ready access of indigent patients to emergency room facilities. The first step in this process is to remove the legal uncertainties surrounding the issue of a hospital's obligation to treat and care for genuine emergency cases."[146] *Rev. Rul. 69-545* helps remove this uncertainty.

Under normal circumstances, a person requiring hospital care is admitted by his personal physician to a hospital at which he has staff privileges. However, this does not usually apply in the case of the poor. They rarely have a personal physician, but instead are dependent upon the emergency room of their local hospital and, if available, its out-patient clinic. The emergency room is often the only available health resource for the poor,[147]

[146] Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901, 911 (1970).

[147] "Finding a physician and getting health care is particularly difficult for families who change communities. A significant portion of these are poor. When health needs become critical, families that do not have adequate financial resources may find emergency rooms and outpatient clinics of general hospitals the only available resource. These families, along with *poor* families, *who often have no other alternative*, have contributed to the 150 million emergency room and outpatient visits in 1967, an increase of 250% during the past two decades." NATIONAL ADVISORY COMM'N ON HEALTH FACILITIES: A REPORT OF THE PRESIDENT 20 (1968) (emphasis supplied).

" . . . the ambulatory care facilities [i.e., emergency services] of the urban general hospital constitute a major medical care resource for the economically deprived, 'core city', minority population groups." *Medical Care in Transition*, 3 AM. J. PUBL. HEALTH 414 (1966).

"A significant phenomenon of contemporary medical care is the evolution of the hospital emergency room into a full-fledged outpatient clinic. Such facilities have become, in effect, twenty-four-hour dispensaries—the place of first resort for an entire spectrum of problems from the coughing child to the critically injured accident vicitim.

"Along with centralization of care, the public must deal with the pressing shortage of physicians, the disappearance

(Footnote continued on following page)

and this utilization of emergency rooms by the poor generally results in their operation at a substantial loss.[148]

Accordingly, the maintenance of emergency facilities by tax-exempt hospitals has been recognized for some time as an important factor in determining their charitable status.

> "The hospitals probably need treat no set number of indigent patients; they can bill all patients and may attempt to collect from all patients. However, the institution's tax exemption is in jeopardy if it refuses emergency hospitilization or treatment to anyone solely because of an inability to pay."[149]

In *City of Palestine v. Missouri Pacific Hospital Association*, 99 S.W.2d 311, 314 (Tex. 1936), the court considered the emergency room facilities in concluding the hospital to be charitable.

> "From time to time emergency cases have been and are being brought to said hospital in physical condition requiring immediate treatnent to save life or prevent further serious physical injury. Regardless of race, creed, financial condition, or any other ground

(Continued from previous page)

of the traditional family doctor, and the disinclination of physicians to make house calls. Moreover, the schedules of medical offices and outpatient departments do not usually coincide with the needs of the working poor."

Cantor, *supra* at 910.

[148] HOYT, CONDITION CRITICAL: OUR HOSPITAL CRISIS 208 (1966):

"One point of loss was the emergency room, and this was true of every hospital that offered emergency services to its community . . . almost half of the emergency room's income was never collected. This was typical; in a check by the Illinois Hospital Association in 1964 the Chicago hospitals reported that they had failed to collect between a third and a half of their emergency room billings."

[149] Horty, *How Does Surplus Affect Tax Status*, 107 MOD. HOSP. 40, 40-42 (July 1966); HOSPITAL LAW MANUAL, *Taxation—State* I:26 (1973).

> or distinction, no such case has ever been turned away from such hospital. . . .[150]

Similarly in *City of Natchez v. Natchez Sanitarium Benevolent Association*, 2 So. 2d 798, 799 (Miss. 1941), the court stated:

> "Under modern conditions, especially as respects serious personal injuries, now happening with more frequency than in the past, it is important in the public interest that persons so injured or taken suddenly and seriously ill shall be immediately treated and cared for at the nearest hospital which may be reached. . . and that a person thereafter found unable to pay shall not be turned out on that account."

Thus, *Rev. Rul. 69-545* continues to impose an important obligation on tax-exempt hospitals to care for those unable to pay, but in different and more meaningful terms than contained in *Rev. Rul. 56-185*.

In addition to understating the importance of emergency room facilities to the poor, plaintiffs have at the same time attempted to obfuscate a significant aspect in the delivery of hospital care, namely, *the fact that indigents are not denied access to in-patient hospital care*. It must be recognized that state, county and municipal hospitals are available to serve indigents and, in fact, were established and are maintained by the various levels of government with taxpayers' money for only one purpose—to provide in-patient hospital care for those unable to af-

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[150] Two of the factors leading the court to reach a favorable decision on tax-exempt status of the hospitals in *Jackson County v State Tax Comm'n.*, 521 S.W.2d 378, 383 (Mo. 1975) were:

> "(a) '8. Each of the hospitals operates emergency facilities on a 24-hour basis.';
>
> "(b) '10. No one requiring emergency treatment has ever been denied it by any of the hospitals for financial reasons.' "

These findings were dispositive of the question posed by the court: "Do the poor have meaningful access to the facilities of St. Luke's, Baptist or Research?" *Id.*

ford it elsewhere.[151] Plaintiffs Hunter, Cook and Lampton (referred to in Pl. Br. at 36) were all receiving care at Charity Hospital at the time they became dissatisfied and sought care from other institutions.[152]

Hopefully, national health insurance, when enacted, will remedy this situation and provide funds to permit all persons their choice of hospital care. However, until that time, our health system provides hospital care in voluntary nonprofit hospitals for the over 96% of the public able to pay the cost thereof, either directly or through some form of health insurance. These institutions are supported by receipts from paying patients and contributions from a public interested in community hospitals providing the highest quality of health care.

At the same time, those unable to pay have access to state, county and municipal hospitals which are supported by taxes paid by the same public whose contributions support the community's voluntary hospitals. Any substantial alteration of this system, if it is not to threaten the financial solvency of up to 3,000 voluntary nonprofit hospitals, should come about through expanded governmental funding of health care for poor by the enactment of a national health insurance program and not by a reversal of the Court of Appeals decision. Such reversal would be tantamount to a judicially enacted national health insurance program, without funding, and would risk widescale financial insolvency in many of our hospitals.[153]

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[151] 1973 AHA GUIDE TO HEALTH FIELDS (Aug. 1973).

[152] Similarly, plaintiffs' chart indicating medium size communities not served by public hospitals (Pl. Br. App. 17A) is deceptive in its implication that hospital care is not available to indigents in communities not served by public hospitals. Except for one questionable reference to a single Kentucky Hospital, there is no evidence in the record to support the implication that voluntary hospitals in communities lacking public institutions do not treat persons unable to pay.

[153] See pp. 47-53 *supra*.

2. Access to Hospital Care Through Medicare and Medicaid Is Important to Persons Below the Poverty Level.

The requirement of *Rev. Rul. 69-545* that services be provided for all persons in the community able to pay the cost thereof, either directly, through private health insurance or with the aid of public programs such as Medicare and Medicaid, is the other important means by which the Ruling carries over the obligation of exempt hospitals to serve the poor. At a time when most of the cost of indigent care is financed by governmental programs, the important question is not whether the hospital is providing unreimbursed services for the poor, but whether it is making its services and facilities available to those for whom reimbursement is provided.[154]

Medicaid is the largest single program for providing health care for the poor. In 1968 payments were made for 13,000,000 people under Medicaid. In 1973 payments rose to an estimated 23,500,000.[155] However, since available data indicates only the number of persons who actually receive Medicaid assistance, rather than the total number of persons eligible for such assistance, the actual number of persons entitled to such benefits is even larger. Effective October 1, 1975, all states will have enacted Med-

[154] There is no legal obligation upon hospitals to provide care for Medicaid patients unless they voluntarily contract to do so. *See* 42 U.S.C. §139a (a) (23) (Supp. IV, 1969). "A section of the [Medicaid] Act known as the 'freedom of choice' provision assured recipients that services could be obtained at the facility of their choice, *provided* that the facility was willing to render services to Medicaid recipients." Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901, 921 (1970) (emphasis supplied, footnote omitted). In *La Crescent Constant Care Center, Inc. v. Minnesota*, 222 N.W.2d 87 (Minn. 1974), the court held that if the resulting state levels were inadequate, the remedy of the individual vendor of medical service is to terminate its relationship with assistance patients.

[155] NUMBER OF RECIPIENTS AND AMOUNTS OF PAYMENT UNDER MEDICAID, NCCS, B-4 NCY-70, Dept. of HEW Pub. # (SRS) 73-03153.

icaid coverage, and although the eligibility levels in some states may be too low to provide universal coverage for all medically indigent persons, the program has benefited millions of poor people and is of undeniable importance to them.

The requirement for providing services to Medicare and Medicaid patients in *Rev. Rul. 69-545* is important to the poor because Medicaid and Medicare are not always economically desirable to a hospital. Although the Medicaid program theoretically requires reimbursement on the basis of cost, on occasion less than cost may be paid.[156] Furthermore, by admitting Medicaid and Medicare patients, a hospital will limit the number of patients who pay charges rather than cost, e.g., self-pay of commercially insured patients.[157]

[156] Idaho Corp. of Benedictine Sisters v. Marks, Civ. No. 1-72-169 (D. Idaho, filed Aug. 29, 1973); *see also*, La Crescent Constant Care Center, Inc. v. Minnesota, 222 N.W.2d 87 (Minn. 1974).

[157] To the extent that Medicaid patients are, in effect, treated at rates which are below cost, *Rev. Rul. 69-545* actually preserves the concept of below cost care in *Rev. Rul. 56-185*. "Any facility currently accepting Medicaid patients will contend, *and probably legitimately so*, that Medicaid reimbursement does not meet full hospital costs; these patients are therefore already being serviced 'below cost.'" Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW AND CONTEM. PROB. 901, 920 (1970) (emphasis supplied).

CONCLUSION

For the above reasons *Rev. Rul. 69-545* is a valid interpretation of section 501(c)(3), and therefore the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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In the Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, et al.,
Petitioners,

vs.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, et al.,
Respondents.

IN SUPPORT OF THE PETITIONERS

BRIEF AMICUS CURIAE OF JACKSON COUNTY, MISSOURI

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ARGUMENT:

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IN SUPPORT OF THE PETITIONERS

BRIEF AMICUS CURIAE OF JACKSON COUNTY, MISSOURI

MOTION OF JACKSON COUNTY, MISSOURI, A POLITICAL SUBDIVISION OF THE STATE OF MISSOURI, FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE

Jackson County, Missouri, a first class county having a charter form of government in the State of Missouri, comes now by and through its Office of County Counselor, and respectfully moves for leave to file a brief *amicus curiae* in support of the petitioners in No. 74-1110, *Eastern*

Kentucky Welfare Rights Organization, et al. v. *Simon, et al.*, as provided for in Rule 42 of the Rules of the U.S. Supreme Court, 28 U.S.C. The consent of counsel for petitioners and respondents has been obtained.[1]

INTEREST OF JACKSON COUNTY, MISSOURI

Jackson County, Missouri is, as noted, a political subdivision of the State of Missouri and is an urban county numbering 654,178 persons at the time of the 1970 census. Under Missouri law (Sections 205.580-.760, R.S.Mo.) the County is charged with the duty of care and relief, maintenance and support of the "aged, infirm, lame, blind or sick persons, who are unable to support themselves, and when there are no other persons required by law and able to maintain them. . ." (Section 205.590, R.S.Mo.). Towards this end the County owns and maintains the Jackson County Public Hospital, a 219-bed medical facility located in the rural part of the County, and has under construction the Truman Medical Center, a 308-bed medical facility located in the County's major metropolitan city, Kansas City. These hospitals are largely financed by public revenues and designed to care for the general public including the poor, as defined above, for both emergency and non-emergency in-patient and out-patient medical services.[2]

1. Consent on behalf of petitioners was granted by Marilyn G. Rose, counsel, on July 21, 1975; consent on behalf of respondents was granted by Stewart Smith, Office of Solicitor General, U.S. Department of Justice, on July 21, 1975.

2. At Jackson County Public Hospital in 1973 the mix of patients was 65% totally indigent, 29% partial pay and only 6% full pay. Thus, 94% of the patients received full or partial subsidy of their health care through public revenues. See Transcript at 34, 46-47, *Jackson County Public Hospital* v. *Blue Cross Association*, No. 74-5, Provider Reimbursement Review Board, Dept. of H.E.W., filed Nov. 1974.

In addition to these hospitals there are some thirteen private voluntary hospitals in Jackson County, which are tax-exempt under Missouri law as charitable institutions. The balance of the hospitals in the County are several small proprietary institutions which are not tax-exempt, a community sponsored hospital devoted to child care, a Veterans Administration facility, and a public hospital owned by Kansas City, Missouri.[3]

Recently the question of continuation of the tax-exempt status of three of the thirteen private voluntary hospitals was decided in an action styled *Jackson County* v. *State Tax Commission*, 521 S.W. 2d 378 (Mo. Sup. *en banc* 1975). The Missouri Supreme Court held, in part, that there was substantial and competent evidence in the State Tax Commission record to continue the charitable tax-exempt status based upon meaningful access of the poor to the three hospitals' facilities. A question was also raised in the cause with regard to mere maintenance of a hospital facility as qualification for tax-exempt status ("the promotion of health is itself a charitable purpose" argued counsel for the hospitals),[4] but was not decided by the Court. The decision also noted that the record showed, among other things, the three hospitals were exempt from federal income tax under 26 U.S.C. § 501(c)(3) as charitable corporations, and because of such exemption status contributions to them were deductible by donors for federal income tax purposes under 26 U.S.C. § 170 (*Id.* at 380).

Jackson County continues to sustain an increase in the number of indigent patients requiring both in-patient and

3. It is anticipated that General Hospital, the 224-bed acute care facility maintained by Kansas City, Missouri, will be phased out of existence upon completion of the adjacent Truman Medical Center now being constructed by Jackson County, Missouri.

4. Appendix I.

out-patient hospital care, but there is not a corresponding increase in public hospital facilities to care for these persons.[5] If Revenue Ruling 69-545 is sustained the general effect and impact upon hospitals operated by governmental units such as counties and cities (especially those situated in urban areas) will be an unmanageable increase in the number of patients at such facilities.

A final approval of Revenue Ruling 69-545 will encourage many of the private voluntary hospitals to refuse admission to *any* indigents for in-patient care while still maintaining their federal tax-exempt status merely on the ground that they operate a medical facility. In fact, Jackson County believes there is presently a movement by such private voluntary tax-exempt hospitals to redefine the exemption towards this end.[6]

The consequence of the foregoing will necessarily result in an abnormal increase in admissions to the public

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5. The County's new Truman Medical Center will replace General Hospital, an old and antiquated facility, owned by Kansas City, Missouri. The net increase in availability of acute care beds to the community will only be 84.

6. Actual practices of the private hospitals support this statement. In the *Jackson County* case, *supra*, the hospitals averred that "no one requiring emergency treatment was ever denied it for financial reasons". This assertion was contradicted by conspicuously posted signs in emergency rooms at two of three hospitals whose exempt status was being tested (Appendix II).

With the abandonment of Revenue Ruling 56-185, the private hospitals in Jackson County apparently realized even those continuing requirements as to out-patient emergency care contained in Revenue Ruling 69-545 would not be enforced. Can one imagine that a poor person would voluntarily seek out or present himself for emergency care at a hospital that posted public signs proclaiming its intention *not* to treat him?

The three hospitals involved in the *Jackson County* case aggregate 1,529 beds and during the 5-year period 1968-1972 averaged, on an annual basis, 47,264 patients treated at their emergency rooms (Appendix II). The Jackson County Public Hospital maintains *only* 219 beds, but treated during 1974 over 36,000 emergency and clinic patients.

hospitals, and, in turn, a quantitative increase in indigent patients could result in a drastic diminution of the quality of hospital services by governmental units such as Jackson County. Revenue Ruling 69-545 is especially onerous in that it occurs at this time when the need for hospital care is on the increase, a situation accentuated by such factors as burgeoning numbers of senior citizens in our national populace, increasing longevity of patients, decreased value of fixed incomes and benefits upon which the aged have to rely for their subsistence, and the continuing nationwide inflationary spiral especially as to such basic necessities as medical care.

The obligation of municipalities, counties and states to afford health care is an ever-broadening one, especially in the last few decades, due not only to the increase of the numbers of patients requiring care, but also to increased responsibilities imposed by state legislative enactments and extensions of coverage as the result of judicial decisions (e.g., *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250 (1974)). Public hospital facilities because of lack of funds are generally limited in size and quality, both as to equipment and staff, whereas many private tax-exempt hospitals are enjoying record-breaking fund raising and attendant construction and expansion programs. In marked contrast is the taxpayer resistance to expansion of public facilities, at least where they must be financed (which is usually the case) by increased taxes or bonded indebtedness. Furthermore Jackson County, like many other cities and counties, has experienced an erosion of its *ad valorem* tax base through the exodus to adjacent less urbanized areas by many of its affluent, prosperous residents, as well as commercial and manufacturing enterprises. The exis-

tence of Medicare and Medicaid coverage, while helpful,[7] is insufficient in amount and duration to cover the actual cost of the County's public hospital care,[8] and normally there is no private hospitalization available to the indigent.

Such rulings as Revenue Ruling 69-545 will in many instances be given considerable weight by state and lesser taxing authorities in determining tax-exempt status based upon charitable character.

Because of the County's concern about the continuation of adequate hospital care not only in Jackson County, but in other urban areas where the problem is equally acute, it is urged that the County's views constitute an important source of information with respect to this challenge of Revenue Ruling 69-545's validity. Additionally Jackson County believes if it had been afforded the opportunity to timely present views and information (i.e., from an urban area's standpoint), Revenue Ruling 69-545 might never have been adopted, or, at the minimum, promulgated in a different text and form.

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7. Administration of the Medicare Program, pursuant to 42 U.S.C. § 1395 *et seq.*, has resulted in disparity of treatment as between private and public hospitals. Costs of essential services provided public hospitals by units of government are not recognized for Medicare reimbursement while similar costs of analogous services are allowed for private hospitals. This double standard imposes a discriminatory burden on the local taxpayer who must fund those costs disallowed by the Bureau of Health Insurance, S.S.A., U.S. Department of Health, Education and Welfare. See Appellant's Brief at 4-14, 26-38, *Jackson County Public Hospital v. Blue Cross Association, supra.*

8. During 1970-74 the County appropriated $14,502,000 to the operations of the Jackson County Public Hospital. This represented approximately 10.1% of the County's entire budget for this 5 year period. The annual appropriation increased from $2,275,000 in 1970 to more than $3,737,000 in 1974, an increase of 64%.

SUMMARY OF ARGUMENT

The growth in the need for in-patient hospitalization, as distinguished from emergency room care, for the medically indigent coupled with the abnormal increase in the cost of such care is resulting in an unmanageable number of these patients for the public hospitals. This is further intensified by the reluctance or refusal of the private voluntary hospitals to accept patients who cannot pay in full. No incentive now exists to offset this unfortunate trend in private hospital admittance policies, which results, in part, from implementation of Revenue Ruling 69-545.

The elimination of any condition requiring the private hospital to provide care free or below cost for those unable to pay is of critical importance to the public hospitals which try to absorb increases in usage with institutions which in many instances, are insufficient as to the number of beds, staff, equipment and other facilities. The effect on the indigent is to reduce (perhaps drastically in some areas) both the availability and quality of health care. Furthermore, this is in accord with the trend among the private hospitals toward a general redefinition of the term "charitable" such as would allow them to be relieved of any obligation to the indigent for in-patient care.

The Court of Appeals concluded that governmental units were "increasingly" providing non-emergency care for those unable to pay, but this conclusion in the context in which it was reached is not supported by the record. Contrary to the assumption of the Court of Appeals, some public hospitals have had to close their doors because of cost factors and other problems, while others are experiencing financial difficulties in a time of rapidly increasing medical costs. Many urban areas are realizing a substan-

tial loss to their tax base because of the movement of many tax-paying families and businesses to suburban areas, which either increases the tax burden on those who remain or makes the public hospitals' share of the tax dollar continously diminish.

The adoption of Revenue Ruling 69-545 means that the private hospitals are able to escape the burden of in-patient care for the indigent while realizing avoidance of any part of the burden of taxation to care for this class of persons. This result allows in effect a subsidy for those who can afford medical care at the expense of those who cannot. This subsidy which is made possible by the national government in the name of our entire citizenry, does not benefit the objects of charity—the indigent—but rather those who are not in need of such help.

The adoption of such rulings as 69-545 serves as important criteria for states and their subdivisions in determining local tax exemptions, so if such a ruling is now upheld it will have a continuing adverse result with reference to present and future local determinations.

No notice or comment period was afforded by the Internal Revenue Service when Revenue Ruling 69-545 was adopted. This is required by the Administrative Procedure Act when a new rule having a substantial public impact is enacted. The impact of this ruling upon both the indigent and the public hospitals is of such consequence that public comment should have been heard by the agency. The action of the agency in adopting this ruling also fell within the proscription of the Administrative Procedure Act as arbitrary, capricious or otherwise unlawful because it was not based upon relevant factors such as the increase of indigent patients, costs, inadequacy of public hospitals, and so forth.

ARGUMENT

I

The Issuance of Revenue Ruling 69-545 Was Erroneous Because It Failed to Consider the Impact of Eliminating the Requirement That Hospital Facilities Seeking the Charitable Exemption Provide Free or Below Cost In-Patient Hospital Care to Persons Unable to Pay, Which Ruling Allows the Private Voluntary Hospitals to Now Divert Any or All Medical Indigents to the Public Hospitals, and Such a Change Was Not Warranted by the Findings of the Internal Revenue Service and the Court of Appeals.

The Court of Appeals in upholding the validity of Revenue Ruling 69-545 reasoned in part that the new definition of "charitable" contained therein was valid because "increasingly counties and other political subdivisions are providing non-emergency hospitalization and medical care for those unable to pay" *Eastern Kentucky Welfare Rights Organization* v. *Simon*, 506 F. 2d 1278, 1288-89 (C.A.D.C. 1974).[9] This conclusion while correct in one sense, has a tendency to be misleading in application, when employed to uphold the subject revenue ruling.

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9. A 308-bed hospital owned by Jackson County, to be known as the Truman Medical Center, is under construction and will be completed in mid-1976. Total cost of this facility is estimated to be $34,575,000.00. These funds represent both county bond monies and grants from the U.S. Department of Health, Education and Welfare. This facility will be operated in conjunction with the University of Missouri's medical school in Kansas City. It only represents a net increase of 84 beds in the community as a municipally owned hospital is being closed down. See n. 3, 5.

(A) The Class of Persons Who Qualify As Indigent for Purposes of Medical Care Is on the Increase, and the Court of Appeals Erroneously Assumed That Local Government Is "Increasingly" Providing Care for These Persons Because This Assumption Is Not Supported in Fact, or by the Record.

Jackson County concurs with petitioners' contentions that the Court of Appeals erred in upholding Revenue Ruling 69-545 because it violates the long-established meaning of the charitable exemption under 26 U.S.C. § 501 (c)(3) of the Internal Revenue Code (Petitioners' Brief at 20-28). But more to the specific interest of political subdivisions such as this County (and those similarly situated in urban areas) is the fact that they are faced with an ever increasing number of persons who need in-patient hospitalization and do not have the resources to obtain the same. Jackson County, under Missouri law, has a duty imposed upon it by statute (Chapter 205, R.S.Mo.) to care for such indigents, and for this purpose a multi-purpose public hospital is now maintained by the County.[10] However, the bed space in this institution, as well as the attendant medical staff and facilities is greatly lacking, which is not the case with local private voluntary hospitals. In fact, as noted by the Missouri Supreme Court in the *Jackson County* case, the three private voluntary hospitals involved therein had "turned a profit for several years, i.e., income has exceeded expenses" (521 S.W. 2d at 381).[11]

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10. Jackson County Public Hospital contains 84 acute care, 9 extended care and 126 long term care beds, as well as dental, alcoholism and emergency care clinics.

11. The State Tax Commission concluded that *each* of the three private hospitals whose charitable tax exemption was being challenged by Jackson County (1) had a "wide reputation for excellence in hospital care", (2) provided a "wide range of medical services to patients", (3) offered "certain medical services

(Continued on following page)

Medical studies have noted that urban public hospitals for the poor throughout the United States, "have long faced difficulties in financing, staffing and operations", which arise from a myriad of causes such as history of such indigent care, financing of such hospitals, and political considerations. In addition to the foregoing, another major factor has appeared, namely the rejection or "dumping" of patients considered "undesirable" by private facilities and referral of these patients to the public hospitals. See Roemer & Mera, *Patient Dumping and Other Voluntary Agency Contributions to Public Agency Problems*, 11 Med. Care Rev. 30 (Jan.-Feb. 1973). A principal concern of Jackson County is that the adoption of Revenue Ruling 69-545 will ultimately result in a substantial or total rejection of indigent and otherwise undesirable patients by many local private voluntary hospitals, which, usually are better funded, staffed and equipped to care for such patients than are the public hospitals.

However despite what Jackson County believes to be an existing disparity, at least, in the quality of services between private and public hospitals, some of the tax-exempt private hospitals have even raised (albeit obliquely)

Footnote Continued—

which are unique", (4) employed "over 1,000 persons with an aggregate employee payroll in 1971 ranging from $7.3 million at [one of the hospitals] to $9.7 million at [another of the hospitals]", (5) had a "large medical and surgical staff ranging from 320 physicians and dentists at [one of the hospitals] to 460 at [another of the hospitals]", (6) received in 1971 "revenues . . . from all sources . . . [which] exceeded the amount of its operating expenses" and (7) applied the "excess of hospital revenues over expenses . . . to retirement of debt, expansion and replacement of facilities, or improvement of patient care." These findings of fact were upheld in *Jackson County* v. *State Tax Commission*, *supra*. Th private voluntary hospital with its fine plant and staff is indeed prospering. Debt is being retired, facilities replaced, and quality of care improved, but not to the benefit of the poor or lower income person who has no admittance rights pursuant to Revenue Ruling 69-545.

the contention that the public hospitals rather than the private hospitals should solely care for the indigent. In the *Jackson County* case the private hospitals in their brief to the Missouri Supreme Court took the position that this Court in *Memorial Hospital* v. *Maricopa County, supra,* had "suggested that the burden of indigent care should be assumed by governmental units rather than hospitals, because adding a major item of indigent care to hospitals will result in arbitrarily forcing paying patients to help finance their indigent neighbors. . ." See Appendix III; also *Validity of Revenue Ruling 69-545*, 48 Hospitals 90 (Nov. 16, 1974).

As indicated earlier it is believed that the class of medically indigent continues to grow, both numerically and proportionally.[12] In 1972 it was estimated that a fourth of all Americans were "indigent or at least medically indigent in the presence of substantial health care costs", and that "despite greater coverage of illness and numbers [by voluntary insurance], out of pocket personal health expenses in the most recent ten year period had almost doubled to $23 billions of dollars." See Wolfe, *Health Care for the Poor: When Oh When?*, 62 Am. J. of Pub. Health 1313-1314 (Oct. 1971). More current estimates, which are set forth in the *amicus curiae* brief filed in this cause by the American Public Health Association, indicate that in 1973, before the current rise in unemployment, persons who might be without economic protection against the costs of hospitalization numbered in the neighborhood of 20 to 25 million persons (APHA *Amicus Curiae* Brief at 16, n. 20; also at 21, n. 38, 39), and many of those with hospitalization insurance maintained coverage inadequate to protect them from the rising costs of hospitalization.

12. In 1973 the Jackson County Public Hospital provided approximately 32,000 persons with in-patient and out-patient care. In 1974 more than 39,000 patients were treated (36,222 out-patient emergency and clinic; 2,803 in-patient).

Nor have Medicaid or similar programs solved the protection problem for in 1974 a large number of low income families were estimated to be excluded from such coverage. See Mueller, *Private Health Insurance in 1973*, 38 Social Security Bull. 21, 22 (Feb. 1975); Butler & Schneider, "Analysis of Title II of S. 2513—Proposal for National Health Insurance," in *Hearings on National Health Insurance before the House Comm. on Ways and Means*, 93d Cong., 2d Sess., Vol. 7, at 3116-18 (1974). Of course, with the increase in unemployment (obviously most critical in the urban areas), a factor which may persist despite substantial economic recovery, there will frequently be occasions on which loss of health insurance coverage will entail for the worker and his or her family. See H.R. Rep. No. 171, Emergency Heath Insurance Extension Act of 1975, 94th Cong., 1st Sess. 20 (1975). When such factors are combined with what this Court has recently termed the "astronomical costs of hospitalization" (*Memorial Hospital* v. *Maricopa County*, 415 U.S. at 265), the limits of the public hospitals will soon be over-taxed, if that point has not already been reached, especially if the private voluntary hospitals are allowed tax-exemption without any in-patient requirement to care for the medically indigent.

The ranks of the medically indigent are also enlarged by virtue of the extension of human longevity coupled with the fact that many of these persons have limited fixed incomes (incomes which are without any regular or adequate cost of living increase mechanisms).

In the face of these problems many governmental units such as Jackson County are hard pressed if not unable to cope with further cost increases. The *amicus curiae* brief of the American Public Health Association noted the

closings of some California public county hospitals because of financial difficulties as well as the additional overcrowding and deterioration of public facilities when indigents are diverted from the tax-exempt private institutions to the public hospitals (APHA *Amicus Curiae* Brief at 27-28). Also see Roemer & Mera, *supra,* and *Doctors Ask: Is this Equal Care?*, 11 Medical World News 17-18 (January 30, 1970).

The U.S. Senate Committee on Labor and Welfare has noted in support of an effort to assist the public urban hospitals "that as a class, large urban hospitals are in greatest need of modernization and have the fewest sources of funds . . . to undertake such needed updating and upgrading of facilities." See S. Rep. No. 1285, 93d Cong., 2d Sess., 4 U.S. Code Cong. Admin. News 7842, 7898 (1975). Political subdivisions are faced with growing competition among all of their vital services (including such responsibilities as public safety, juvenile institutions, roads, welfare, parks, as well as health care) for their shares of the local public revenues, which further exacerbates the problem. This County like many other urban counties has experienced a steady eroding of its tax base by the movement of many of its tax-paying families and enterprises to neighboring counties, both in Missouri and Kansas, without a corresponding influx of same, thereby creating a long range impairment of sources of local revenue.[13]

In this context, Jackson County believes Revenue Ruling 69-545 represents an open invitation to the private

13. This problem is heightened by the fact that thirteen large private hospitals, located within Jackson County and aggregating more than $106 million in appraised valuations, are exempt from *ad valorem* taxes despite full use and enjoyment of the benefits and services of local government. In March, 1975, tax assessments in excess of $32,000,000 were stricken from the tax rolls of the Division of Assessment pursuant to the Missouri Supreme Court's decision in the *Jackson County* case, *supra.*

hospital to reject any or most in-patient care for the medically indigent and thereby transfer these persons to the public hospital. Evidence of this attitude is suggested by comments on the subject Court of Appeals' decision which were contained in the *Journal of the American Hospital Association.* Noting that Revenue Ruling 69-545 was an alternate to Revenue Ruling 56-185, which carried "with it an obligation of charity service", the *Journal* quoted an American Hospital Association spokesman as saying "that the decision should remove delays in tax exemption determinations that have been experienced recently by some hospitals," *Validity of Revenue Ruling 69-545,* 48 Hospitals 90 (Nov. 16, 1974). As previously indicated there was analogous contention by the hospitals made to the Missouri Supreme Court in the *Jackson County* case, though the issue was not decided. See Appendix I.

(B) The Elimination of the Requirement to Furnish In-Patient Hospital Care Allows the Tax-Exempt Private Hospitals (and the Patients Therein Who Are Capable of Paying for Their Care) to Enjoy the Benefits Provided by Tax Revenues, While Avoiding Any Tax Liability; and Revenue Ruling 69-545 Thereby Discriminates Against Both the Indigent and the General Public.

Generally the grant of a charitable exemption requires that the asserted charitable use be such that a burden or public function is discharged which would otherwise fall upon government. See 84 C.J.S., *Taxation,* Sec. 297. Yet the effect of Revenue Ruling 69-545 is directly to the contrary because it removes an important responsibility from the private hospital to furnish care for the indigent, and shifts the totality of this burden to the public hospitals. Unfortunately, in actual practice the ruling also relieves

the private hospitals of any liability to pay federal taxes, part of which would ultimately help fund public hospitals by way of such devices as grants-in-aid, Medicare or Medicaid reimbursements, or matching funds; and thus the ruling eliminates, for all intents and purposes, any private hospital obligation to share the in-patient problems of the medically indigent.

In a very real sense Revenue Ruling 69-545 has a self-defeating character through the removal of any incentive or requirement in its application. And, as a direct result, there is a subsidization of the private hospital industry by the taxpayers, which constitutes a windfall to the affluent, compounded by the industry's denial of benefits to the economically disadvantaged.

If the private hospitals paid taxes and thereby shared in the burden of providing health care to the poor through the publicly financed hospitals, then their exclusionary policies as to indigents might have some logical basis. In the present circumstance, however, having taken advantage of the tax laws to escape liability, and thereby avoiding any part of the burden of financing public facilities, the private hospitals' non-accessibility to the poor frustrates the basic reason underlying the grant of exemption.

Jackson County therefore contends that adoption of Revenue Ruling 69-545 (which contains no requirement that a hospital facility affirmatively demonstrate that it accepts and cares for in-patient medically indigent) discriminatorily shifts the burden for indigent health care to the public hospitals. In Jackson County, the federal tax exemption provides private hospitals (and their affluent or insured patients) with a form of national subsidization at the expense of the property tax burden borne by Jackson Countians in order to treat the poor of this community who

remain invisible to, or may have been denied care by the local exempted institutions.[14]

Public hospitals are not in a position to handle this misplaced burden due to the financial and political factors which impinge upon them. The ultimate result will be to deprive the indigent of the availability of quality hospital services while subsidizing such care for the affluent already capable of paying for same.

II

The Adoption of Revenue Ruling 69-545 Would Have an Adverse Effect Upon Tax Exempt Determinations by States Such As Missouri, Which Rely Upon Such Criteria, in Part, When Making Determinations As to Charitable Exemption From Taxation.

Revenue Ruling 69-545 is important from Jackson County's standpoint because such ruling plays a significant role as criteria in determining the tax-exempt charitable status of the private voluntary hospitals in Missouri.[15]

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14. The private hospitals do not admit that any substantial numbers of persons are "medically indigent". In the *Jackson County* case, *supra*, it was urged that there is no such "equation that the poor equal the medically indigent". In fact, statistics were cited to the Missouri Supreme Court to the effect only "3.43 percent of the civilian resident population" were "medically indigent persons". (Although, even the private hospitals noted that this "3.43 percent" numbered 6,892,000 men, women and children.) See Appendix IV.

The possibility must be considered therefore that the indigent are *invisible* to the private hospitals if they sincerely believe the poor do not exist in significant numbers. And, if the "medically indigent" *only* number 6,892,000 persons, are not the health care needs of each of these, as well as the magnitude of such total figure, important and socially significant?

15. Counsel for hospitals seeking tax exemption in Missouri cite federal tax exemption to Missouri courts to support and justify, in part, the hospitals' claims regarding their alleged charitable purposes. See Appendix V.

In 1972 when the status of three of the largest and most profitable private voluntary hospitals within this County was initially considered by the State Tax Commission, one of the findings of fact cited to support a ruling that the hospitals were "charitable" (and therefore exempt) was that each hospital had received a determination from the Internal Revenue Service that it was exempt from federal income tax as an organization described in 26 U.S.C. § 501(c)(3), and that contributions to each hospital were to be deductible for federal income tax purposes under 26 U.S.C. § 170. The Commission also found that each hospital accepted and admitted indigent patients. These findings were recited by the Missouri Supreme Court in its review of the Commission's holding. See *Jackson County* v. *State Tax Commission*, 521 S.W. 2d at 380.

Missouri courts have on other occasions held that determinations by other taxing authorities have a bearing upon similar determinations on the state level in considering tax exempt status. In *Northeast Osteopathic Hospital* v. *Keitel*, 355 Mo. 740, 197 S.W. 2d 970, 974 (1947), it was held where federal taxing agencies have administratively determined a hospital to be exempt from taxation on charitable grounds that if such exemption was determined upon the same, or, in effect, like language in underlying legislation of like purpose then such a determination is persuasive.

If the criteria set forth in Revenue Ruling 69-545 continue to be implemented, then such will have a substantial influence on the determinations by the various states and subdivisions thereof as to tax exempt status of hospitals on charitable grounds. The thrust and impact of this ruling inevitably encourages a redefinition which Jackson County maintains will result in the shedding by the private hospitals of *any* liability for the care of the poor and economically disadvantaged. The private hospitals will

exclusively serve the affluent and the fully insured while enjoying the subsidy of tax exemption authorized by the federal government on behalf of all citizens—both affluent and indigent.

III

The Substantial Impact of the Changes Made by Revenue Ruling 69-545 Required Compliance by the Internal Revenue Service With the Administrative Procedure Act As to Notice and Comment Period, and the Ruling Is Further Unlawful, Under the Administrative Procedure Act, Because Such Is Not Supported by Relevant Information in the Record.

The elimination in Revenue Ruling 69-545 of the requirement that free or below cost care (including in-patient hospitalization) be provided those who are unable to pay as a condition for charitable exemption from federal taxation has a basic and substantial impact upon the medically indigent, as well as on the public hospitals. In such a case the rule-making procedures of the Administrative Procedure Act (5 U.S.C. § 551 *et seq.*) should have been strictly adhered to; i.e., notice in the Federal Register and allowance of a period for comment by interested members of the public was mandatory (5 U.S.C. § 553 [b], [c] and [d]).

A failure to follow proper procedures denied the public any expression of their views on the proposed rule, and eliminated an educational process required of the agency under the Administrative Procedure Act's guidelines for enactment of rules having substantial impact. Indeed, neglect by an agency to afford proper notice and period for comment will invalidate a rule. *Texaco* v. *Federal Power Commission*, 412 F. 2d 740, 743-745 (C.A. 3, 1969); *Lewis-Mota* v. *Secretary of Labor*, 469 F. 2d 478, 481-482 (C.A. 2, 1972). Also see *NLRB* v. *Wyman-Gordon Co.*, 394 U.S. 759, 764-765 (1969).

Furthermore in implementing a significant change relating to indigent health care the Internal Revenue Service appears to have excluded any consideration of the effect upon the public hospitals (and, consequently, upon the availability and quality of health care delivered to indigents). This is exactly the type of arbitrary capricious or otherwise unlawful action proscribed by 5 U.S.C. § 706 (2) (A).

A government official or agency, in the decision making process, must make judgments upon fair consideration of all the relevant factors, and a failure to do so is violative of 5 U.S.C. § 706(2) (A). See *Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402, 416 (1971). Therefore, Jackson County urges Revenue Ruling 69-545 be set aside for non-compliance by the Internal Service with the Administrative Procedure Act's requirements.

CONCLUSION

For the reasons stated above, this Court should rereverse the judgment of the Court of Appeals and remand this cause to the District Court.

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APPENDIX I

B. The Promotion of Health Is Itself a Charitable Purpose.

The author of the most frequently cited treatise on the law of trusts states the proposition simply: "It is well settled that the promotion of health is a charitable purpose." *Scott on Trusts*, 3rd ed., Sec. 368, p. 2853. With equal clarity other treatise writers[6] and the Restatement of Trusts[7] recognize the promotion of health as a charitable purpose. Those authorities support the rule with abundant case citations.

A thorough discussion of the definitions of "charitable" in Missouri law is contained in Judge Otis' opinion in *Irwin* v. *Swinney*, 44 F.2d 172 (D.C.Mo. 1930). In that case the Court recognized hospitals as charitable *per se*, since they serve the sick, stating:

> "The words 'hospital,' 'infirmary,' 'educational,' 'scientific,' and 'libarary' require no especial discussion, since they are clearly either within the letter of the statute of Elizabeth or 'within its spirit, equity and analogy.' The statute does not mention 'hospitals' and 'infirmaries' by name, but it refers to gifts for the 'relief of aged, impotent, and poor people' and for 'the maintenance of sick and maimed soldiers and mariners.' Certainly 'hospitals' and 'infirmaries' are for these and analogous purposes. Moreover, the Supreme Court of Missouri expressly has held, relying

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6. *Bogert, Trusts and Trustees*, 2d ed., Sec. 374, p. 107; 15 Am. Jur. 2d 156-157.

7. 2 *Restatement of Trusts* 2d, Sec. 372, p. 255.

for precedent upon a case (*Wakering* v. *Bayle*, Proceedings in Chancery, vol. I) anteceding the statute of Elizabeth, that a bequest for the erection of a hospital created a charitable trust. *Buchanan* v. *Kennard*, 234 Mo. 117, 136 S.W. 415, 37 L.R.A. (N.S.) 993, Ann. Cas. 1912D, 50," (at p. 175).

This Court in the *Northeast Osteopathic Hospital* case, supra, confirmed that the relief of suffering and disease is itself charitable, stating:

"'A charity, in the legal sense may be more fully defined as a gift, to be applied consistently with existing laws, for the benefit of an indefinite number of persons . . . by relieving their bodies from diseases, suffering or constraint . . .' *State ex rel. Alexian Brothers Hospital* v. *Powers*, 10 Mo. App. 263, aff'd 74 Mo. 476." (197 S.W.2d at 975).

As will be further discussed, on June 10, 1974, Division Number One of this Court decided a sales tax case sustaining the exemtpion of hospital coffee shops, cafeterias and gift shops, a decision premised on the finding that nonprofit hospitals are charitable. *St. John's Medical Center, Inc.* v. *Spradling*, 510 S.W.2d 417 (Mo.Sup. 1974). In that case, the Attorney General, as guardian of public revenues, was seeking additional taxes. His brief concedes, however, that "the providing of health care" is the "charitable function" of hospitals, and that there is no question

about the general "charitable or tax exempt status" of nonprofit, general hospitals (App. Br. 11, 8, 18 in No. 58,191).[8]

Source: Appellants' Brief at 34-36, *Jackson County* v. *State Tax Commission*, 521 S.W.2d 378 (Mo. Sup. en banc 1975).

* * *

". . . other jurisdictions have uniformly rejected the proposition that the test of a charitable hospital turns on the extent of free services rendered."[23]

Source: Appellants' Brief at 44-45, *Jackson County* v. *State Tax Commission, supra.*

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8. See also the recent student note on "Charitable Trusts—Validity of Devises to Unspecified Charities," 39 *Mo. Law Review* 51 (Winter, 1974), where it is again stated that "valid charitable objects include the relief of poverty and the advancement of . . . health . . . or any other purposes that benefit the community." (at 54). As Mr. Justice Blackmun recently observed in *Alexander* v. *"Americans United", Inc.*, ... U.S. ....., 94 S.Ct. 2053, 2065, note 10 (1974) (dissenting on other issues) the legal use of the word "charitable" may have certain "idiosyncrasies." It is a term of art, however, after nearly four centuries of legal interpretation; whatever may be the outer limits of "charitable" activity, in legal usage the term has always included health care as a separate element.

23. "[W]ithout doing any free work of any kind, [a] hospital would still be a charitable corporation so long as its surplus income is applied to the support, maintenance, and enlargement of the hospital and its facilities." *Weiss* v. *Swedish Hospital*, 16 Wash.2d 446, 133 P.2d 978, 980 (1943); see also *In re Henderson's Estate*, op. cit. supra at 608; *Bishop of St. John the Evangelist* v. *Treasurer*, 37 Colo. 378, 86 P. 1021 (1906).

APPENDIX II

". . . no one requiring emergency treatment was ever denied it for financial reasons . . ."

Source: Appellants' Brief at 62, *Jackson County* v. *State Tax Commission, supra.*

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"45. Appellants' glib references to 'no one requiring emergency treatment was ever denied it for financial reasons' and 'utilization of emergency rooms by the poor' contrast sharply with the record which contains no evidence with respect to any actual amounts of free emergency care. These assertions also are contradicted by conspicuously posted signs in emergency rooms at two of the hospitals (September 8, 1974) which state as follows:

At Research (2 signs—one adjacent to only entry to emergency care facility; the other adjacent to desk at which prospective emergency patient is admitted) . . .

'1. This is not a free clinic.

2. Twenty four hour coverage provided by licensed emergency physicians and increased costs of health services make the following minimum charges necessary.

3. Minimum fees are charged *all* patients as follows:

Hospital	$13.00
Physician	$10.00

4. Additional fees may be charged depending on type and extent of services received.

5. Payment in full is requested at time of service.' (Emphasis appears in signs).

At Baptist (1 sign located immediately above area where prospective emergency patient is admitted) . . . 'Cash payment upon dismissal requested for all emergency or out patient services.' "

Source: Respondents' Brief at 75-76, *Jackson County* v. *State Tax Commission, supra.*

• • •

"St. Luke's is the largest hospital in Jackson County with 634 beds in 1972, 30 additional intensive care beds then under construction, a separate School of Nursing and residence quarters, and the Helen F. Spencer Center for Education, used primarily for medical education (St.L.D.R. 103; St.L. Tr. 16, 17). Baptist is a 378 bed hospital and in 1972 had under construction an addition to house its educational programs, a new clinical laboratory and physical therapy facilities (B.D.R. 106-107; B. Tr. 19, 20). Research is a 517 bed hospital with residence structures for student nurses, paramedical students and for certain hospital staff (R.D.R. 99; R. Tr. 9-14)."

Source: Appellants' Brief at 5-6, *Jackson County* v. *State Tax Commission, supra.*

• • •

"The aggregate number of emergency room visits during the past five years for each of the hospitals is as follows:

St. Luke's	75,206
Baptist	77,289
Research	83,829

(St.L.D.R. 125; B.D.R. 123; R.D.R. 119)."

Source: Appellants' Brief at 6-7, *Jackson County* v. *State Tax Commission, supra.*

APPENDIX III

"While the taxing authorities . . . have been casting about for some required percentage of indigent aid, no argument has been made, and it was not suggested by the Court below, that free clinics alone qualify as tax exempt hospitals.[26]"

Source: Appellants' Brief at 46-47, *Jackson County* v. *State Tax Commission, supra.*

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26. "The argument of the quota seekers seems directed toward legislative considerations, and does not seem truly intended to develop judicial interpretations of the existing provisions of law. At the risk of joining issue with the County on a question not properly to be resolved at the judicial level, it may be observed that the United States Supreme Court in an opinion this year has suggested that the burden of indigent care should be assumed by governmental units rather than hospitals, because adding a major item of indigent care to hospital budgets will result in arbitrarily forcing paying patients to help finance their indigent neighbors; and the extra charge on the hospital bills will come at a time when paying patients can perhaps least afford such a burden. *Memorial Hospital* v. *Maricopa County,* ..... U.S. ....., 94 S.Ct. 1076, 1085 (1974)."

APPENDIX IV

"In 1970 less than 4% of the civilian population was both below the poverty level and not covered either by Medicare or Medicaid.[28] Between 1968 and 1973 payments under Medicaid, the largest single program for providing health care to the poor, rose from 13 million recipients to 23.5 million.[29]

It may be concluded that persons of moderate income, not those below the poverty level, are most endangered by medical costs, and these persons do not generally seek to be treated as "objects of charity" in the alms-giving sense. At the end of 1971 the net number of persons under age 65 with some form of private hospital insurance has been estimated at 147 million or 80% of the civilian population.[30] This should not be interpreted, however, as indicating that 80% of health care costs for persons under 65 are insured, since (1) a far smaller percentage of the population has insurance coverage for physicians' expenses and other non-hospital health care costs, and (2) virtually all private hospital insurance imposes limitations, maximums, deductibles, co-insurance requirements and similar provisions which result in the insured shouldering a substantial part of hospital costs. National expenditures for all health care costs totaled $69 billion in 1971, and were paid from the following sources:[31]

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28. Appendix I

29. Appendix II

30. These estimates are Office of Research and Statistics projections published in *Social Security Bulletin,* Feb. 1973, Vol. 36, No. 2, p. 7.

31. Cooper and Worthington, *National Health Expenditures, Calendar Years 1929-71* (Research and Statistics Note No. 3), Office of Research and Statistics, 1973, summarized in *Social Security Bulletin,* Feb. 1973, Vol. 36, No. 2, p. 22."

Private health insurance	25.9%
Out-of-pocket payments by consumers	36.5%
Public funds	36.1%
Philanthropy	1.4%"

Source: Appellants' Brief at 47-48, *Jackson County* v. *State Tax Commission, supra.*

"Appendix I

Health Insurance Coverage of Medically Indigent Persons

	Persons (in thousands)
Persons below poverty level in 1970 (12.6% of population)[1]	25,420
Less: 65 and over presumably eligible for Medicare[2]	(1,188)
Total persons under 65 below poverty level	24,232
Less number of recipients of Medicaid 1970[3]	(17,340)
Total estimated number of medically indigent persons in U.S.A. 1970[4]	6,892
United States civilian resident population April 1, 1970[5]	201,064

1. U.S. Bureau of Census, Department of Commerce, *Current Population Reports*, Series P-60, No. 86.

2. Department of Commerce figures from *A Guide to Consumers Markets*, The Conference Board Report, No. 67, pg. 140.

3. *Numbers of Recipients and Amounts of Payments Under Medicaid* 1970, DHEW Publication Uo. (SRS) 73-03153 NCSS Report B-4 (CY 70) pg. 1.

4. This would be a maximum figure, as it would include eligible persons who did not seek Medicaid assistance.

5. Data are census enumerations as of April 1, 1970; Source: Department of Commerce figures from *A Guide to Consumer Markets*, The Conference Board Report, No. 67, pg. 10.

In 1970, with a civilian resident population of 201,-064,000,[5] there were 25,420,000[1] persons below the Department of Commerce's defined poverty level. Of these persons below the poverty level, 1,188,000[2] were aged 65 or older and presumed eligible for Medicare, resulting in 24,232,000 persons under 65 and below the defined poverty level. These persons under 65 and below the defined poverty level were eligible to receive health care from the Medicaid programs, of which there were 17,340,000 recipients in 1970 according to Department of Health, Education and Welfare.[3] This results in 6,892,000 medically indigent persons, which represents 3.43 percent of the civilian resident population. This means that 96.57 percent of the civilian resident population is *not* medically indigent.

Appendix II

Receipt of Medicaid Benefits

Years	Number of Medicaid Recipients
1968	13,000,000
1969	14,875,000
1970	17,340,000
1971	20,667,000 (est)
1972	22,465,000 (est)
1973	23,500,000 (est)

Source: Number of Recipients and Amounts of Payments Under Medicaid NCSS B-4 NCY-70, Department of HEW Pub # (SRS) 73-03153"

Source: Appellants' Brief at 91-92, *Jackson County* v. *State Tax Commission, supra.*

APPENDIX V

The Circuit Court Erred in Its Interpretation of the Federal Income Tax Law of Charitable Hospitals and the Effect of Such Law on This Case.

Section 501(c)(3) of the Internal Revenue Code (26 U.S.C.) exempts from federal taxation organizations which are organized and operated "exclusively for . . . charitable . . . purposes." Donations to Section 501(c)(3) organizations are deductible for federal income tax purposes.

As stipulated by the parties, St. Luke's, Baptist and Research have each been determined to be tax exempt by the Internal Revenue Service under Section 501(c)(3) (St.L.D.R. 104-105; B.D.R. 108-109; R.D.R. 100-101). We have consistently acknowledged that such determination is not controlling for purposes of tax exemption under Missouri law. Nevertheless, it is highly persuasive and "entitled to respectful consideration." *Northeast Osteopathic Hospital* v. *Keitel*, 355 Mo. 740, 197 S.W.2d 970, 974 (1946).

• • •

The Circuit Court has failed to accord those federal tax exemptions—and the exemptions each hospital enjoys from Missouri State Income Tax and sales and use taxes—the "respectful consideration" which is their due. *Northeast Osteopathic Hospital* v. *Keitel*, supra, 197 S.W.2d at 974. Source: Appellants' Brief at 77, 80, *Jackson County* v. *State Tax Commission, supra.*

MOTION FILED

OCT 28 1975

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The United Methodist Church and the American Association of Homes for the Aging respectfully move this court for leave to file the accompanying brief in this case as *amicus curiae*. The consent of the attorney for The Secretary of the Treasury, Et Al. has been obtained, but the attorney for Eastern Kentucky Welfare Rights Organization, Et Al. refused to consent to the filing of a brief by the United Methodist Church and the American Association of Homes for the Aging as *amicus curiae*.

The applicant United Methodist Church has an interest in this case in that it sponsors, through its Division of Health and Welfare Ministries, numerous non-profit hospitals and homes for the aged across the county. Most of these institutions now enjoy 501(c)(3) exemption from federal income taxes. In both the continuation of their exemption from federal income taxation and in state exemptions from ad valorem property taxation, the legal definition of "charity" is all-important. Whether a "charitable purpose" under a variety of tax laws includes the promotion of health and other activities socially beneficial in themselves—but not necessarily dependent on their provision for free or below cost—may mean the life or death of many of these institutions, or at the very least, increased financial burdens on aged and infirm patients and residents already in hardship. The decision in this case may be expected to carry great weight in state-level judicial and legislative determinations of tax-exempt status for such institutions, since the legal definition of "charity" is the singularly most important issue in those determinations.

This applicant can present the view of the church-related hospital and home for the aged—institutions which could be crippled by an adverse decision in this case. Their position is decidedly *not* one taken against the concept of the provision of free or below-cost services to those in need, a concept to which the United Methodist Church and its Health and Welfare Ministries Division have always and unwaveringly been dedicated, but instead one supporting the position that all infirm and aged people bearing the extra burdens of health and finance needs should be assisted through tax exemption for such non-profit facilities.

The applicant American Association of Homes for the Aging has an additional interest. It is a national membership organization of non-profit facilities for the care of the aged, typically sponsored by churches of almost every religious faith. Non-profit homes for the aged are broadly dependent on tax exemption (from both federal income taxes and state and local property taxes) based on their "charitable" nature—exmeptions which could be lost by a judicial re-definition of "charity".

The brief of the Secretary of the Treasury herein argues that the Revenue Ruling 69-545 provides an appropriate interpretation of the term "charitable" in Section 501(c)(3) of the Internal Revenue Code. The applicants herein believe that their experience with a variety of charitable exemption laws in cases in most of the fifty states and their broad experience in charitable works provides background to expand on this argument of the Secretary, and provide an enlarged insight to the legal definition of "charity" and the great impact the decision in this case may have on laws affecting taxation—both on income and

property—of hospitals and other kinds of charitable institutions across the nation.

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INTEREST OF THE AMICUS

This Brief is presented on behalf of the United Methodist Church and the American Association of Homes for the Aging. Their respective interests in this case are described in the foregoing Motion for Leave to File Brief as *Amicus Curiae*. In summary, the United Methodist Church, through its Division of Health and Welfare Ministries, sponsors numerous non-profit hospitals and homes for the aging in most of the fifty states. The American Association of Homes for the Aging is a membership organization of non-profit facilities for the elderly across the nation. The interest of these organizations derives from the important role of tax exemption to most of their institutions, and their position that a legal redefinition of "charity" by this Court would have a profound effect on judicial and legislative determinations of exemption—both from income and property taxes—at state and local levels across the nation, most of which are traditionally based on the legal definition of "charity" or "charitable purpose."

QUESTION TO BE DISCUSSED

It is recognized that there are important procedural issues in this case. However, the United Methodist Church and American Association of Homes for the Aging will discuss only the substantive issue of whether Revenue Ruling 69-545 is consistent with Section 501(c)(3) of the Internal Revenue Code, and therefore, whether the criteria set forth in Revenue Ruling 69-545 properly describe a "charitable purpose."

Additionally, it is noted that the law as regards hospitals on this specific issue has been carefully and thoroughly briefed in this case by the American Hospital

Association as *amicus curiae*, and reiteration of that organization's position will be avoided.

The United Methodist Church and American Association of Homes for the Aging will direct discussion toward the legal definition of "charity" and "charitable purpose" with emphasis on the possible impact on non-profit hospitals and homes for the aging across the nation, both in terms of 501(c)(3) exemption and property tax exemptions.

SUMMARY OF ARGUMENT

"Charitable purpose," as used in Section 501(c)(3) of the Internal Revenue Code, is not restricted to the narrow popular meaning of relief of poverty, but extends to the generally accepted, and more broad, legal meaning. The majority rule in the United States, developed in cases on a variety of tax-exemption schemes but all turning on the definition of "charity" or "charitable purpose," is that these words encompass a good deal more than mere almsgiving. They include many forms of public beneficence, including various enterprises dedicated to the general improvement of mankind, even if operated at moderate cost to the beneficiaries, provided that there is no profit or private benefit inuring to the trustees, sponsors or any other individual. Non-profit hospitals and non-profit homes for the aging are these kinds of enterprises.

Tax exemption is vital to non-profit hospitals and non-profit homes for the aging, and the loss of such status would result in failure of many such institutions, or at the very least substantial increases in cost to already heavily-burdened beneficiaries—not to mention the increased direct burden on government. A decision adverse

to the Secretary of the Treasury in this case would deal a direct blow to non-profit hospitals, and at least an indirect effect on homes for the aging. Additionally, such a decision may be expected to have a dramatic effect on the status of property tax exemptions at state and local levels, almost all of which revolve around the legal meaning of "charity".

Prevailing American law recognizes the broad meaning of charity as including these kinds of socially beneficent activities, even where the direct relief of poverty is not involved. Thus, Revenue Ruling 69-545 is consistent with the generally accepted legal definition of "charitable purpose," and is thus a proper interpretation of Internal Revenue Code Section 501(c)(3).

ARGUMENT

I.

"Charitable Purpose," As Used in Section 501(c)(3) of the Internal Revenue Code, Is Not Restricted to the Relief of Poverty but Extends to Broader Forms of Public Beneficence, Such As Practical Enterprises for the Good of a Certain Portion of Humanity With Special Needs Recognized by Society, Operated at Moderate Cost to the Beneficiaries, but Without Profit or Private Benefit to Their Trustees, Sponsors or Any Other Individual.

Section 501(c)(3) of the Internal Revenue Code of 1954 exempts from Federal income taxation organizations "operated exclusively for . . . charitable . . . purposes, . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual . . ." Federal Tax Regulations provide that the term "charitable" in Section 501(c)(3) is used in the "generally accepted legal sense." Treas. Reg. §1.501(c)(3)-1(d)(2) (1959).[1]

What is the generally accepted legal sense of "charitable?" The word "charitable" is not limited to a static, narrow meaning under the law; it changes to keep pace with the development of our society—it expands to meet the needs of social advancement.

---

1. Treas. Reg. §1.501(c)(3)-1(d)(2) has been in effect since 1959, unamended through several amendments to the Internal Revenue Code provisions relating to exempt organizations, and may therefore be said to have tacit Congressional approval. The position that the use in 501(c)(3) of "charitable" intends its generally accepted legal sense and not a limited popular sense is also supported by Federal case law. See, for example, *Green* v. *Connally*, 330 F. Supp. 1150, 1157 (D.D.C. 1971), *aff'd per curiam sub nom. Coit* v. *Green*, 404 U.S. 997 (1971).

"It must never be forgotten that the words 'charity' and 'charitable' are technical terms. Since the Statute of Elizabeth, they have had a technical meaning both in England and America, including even those states in which the statute has been repealed or has not been reenacted or adopted.

> 'They are lifted from their popular and lexicographical meaning. In them survives a history from which they have derived a special significance. They condense volumes of controversy and decision into a phrase which must be now read by the growing light under which it has been developed.' "

Zollman, *American Law of Charities*, pp. 122-123, Bruce Pub. Co., 1924.

In the legal sense, "charity" is given a meaning as broad as the generally recognized needs of society, so long as the organization dedicated to meeting them does so without profit or advantage to itself:

> "Although the relief of the poor, or a benefit to them in some way, is in its popular sense a necessary ingredient in a charity, this is not so in the view of the law, and hence a gift to a public use is not unlawful as a charity because it is not limited to the purpose of relieving the sick or poverty stricken, or because it extends to the rich as well as to the poor. A charitable use, where neither law nor public policy forbids, may be applied to almost anything that tends to promote the well-being of social man." 14 C.J.S., *Charities*, pp. 440-441, §12.

This broad view of the legal meaning of "charity" has long been the rule in Federal tax cases. A good long-standing collection of judicial definitions of the term "charitable"

is set forth in *George G. Turnure*, 9 B.T.A. 871 (1927) (Non-Acq.):

> "Charitable" may be used in either a broad or a narrow sense. In its narrow sense, charity means whatever is bestowed gratuitously on the needy or suffering for their relief. In its widest sense, charity denotes all the good affections which men should bear to each other, and in that sense embraces what is generally understood as benevolence, philanthropy, and good will.
>
> A definition of charity used by counsel in the case of *Vidal* v. *Girard*, 2 How. 127, and subsequently quoted with approval in many courts, including the Supreme Court (*Ould* v. *Washington Hospital*, 95 U.S. 303), is as follows: "Whatever is given from the love of God, or for the love of your neighbor, in the catholic and universal sense, given from these motives and to these ends, free from the stain or taint of every consideration that is personal, private or selfish."
>
> In the last cited case it is said: "A charitable use, where neither law nor public policy forbids, may be applied to almost anything that tends to promote the well-doing and well-being of social man."[2]

American law has traditionally recognized the charitable nature of not-for-profit enterprises dedicated to the

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2. For other consideration of the broad meaning of the term "charitable" see *Underwriters' Laboratories, Inc.* v. *Commissioner*, 135 F.2d 371 (7th Cir. 1943), *Robert W. de Forest*, 19 B.T.A. 595 (1930) (Acq.), and more recently *Lorain Avenue Clinic*, 31 T.C. 141 (1958), in which the Tax Court notes that "charitable" is to be construed in accordance "with the meaning in the law of charity which is, generally, a trust for the relief of poverty *and for other purposes beneficial to the community.*" (Emphasis added.)

good of humanity, even where the direct beneficiaries of that dedication are charged moderate fees. Charity has traditionally been held to include:

> "Public beneficence, such as practical enterprises for the good of humanity, operated at moderate cost to the beneficiaries, or enterprises operated for the general improvement and happiness of mankind, . . . provided its income is not used, nor intended to be used, as dividends or profits." *Williamson* v. *Housing Authority,* 186 Ga. 673, 199 S.E. 43 (1938), citing other cases.

The rules of American cases on point are summarized in RESTATEMENT (SECOND), TRUSTS:

> "§368. Charitable purposes include . . . other purposes the accomplishment of which is beneficial to the community . . .
>
> "§372. A trust for the promotion of health is charitable . . . Comment: b. *Charging fees.* A trust to establish or maintain a hospital is charitable, although it is provided that the patients shall pay fees . . .
>
> §374. A trust for the promotion of purposes which are of a character sufficiently beneficial to the community to justify permitting property to be devoted forever to their accomplishment is charitable."

We in the United States are moving rapidly into an era when modern social legislation dramatically denies the stereotyped image of the destitute pauper, the truly "poor" of Dickensian characterization. Today, Social Security, pensions, and other prevalent sources of third-party payor programs increasingly assure that institutions rendering much needed services will receive some payment from, or on behalf of, the beneficiaries of these services. Today we

see public welfare support for those in finanical need clothed with the mantle of a virtual *constitutional right.* (See *Goldberg* v. *Kelly,* 397 U.S. 254, 25 L.Ed.2d 287, 90 S.Ct. 1011 (1970)).[3]

Many institutions such as hospitals and nursing homes which in earlier days before the advent of these modern social programs were furnishing a substantial degree or percentage of such "free" care now find that potential recipients of such "almsgiving" infrequently appear, if at all. This is the encouraging result of our changing attitude toward poor and low-income people in our society, as reflected in current social legislation. The plight of the poor in our country is still a grave one, and a glib gloss-over treatment of their problems is dramatically rejected here. Yet the fact remains that hospitals and homes for the aged are increasingly reimbursed by third parties for their care of the indigent. This circumstance hardly reflects any kind of hardening of the heart on the part of such institutions toward the poor.

Courts generally have not been misled by this evolving circumstance of society. They are recognizing the interwoven fabric of social legislation and contractual rights which result in nearly everyone being "paid for"—whether directly from personal funds or indirectly. One of the earlier but still recent judicial recognitions of this modern

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3. In *Law of the Poor,* La France, et al., West Publ. Co., St. Paul, 1973, the authors point out that welfare law litigation only "emerged in the last half of the 1960's", and that prior to 1965 there were only a handful of cases dealing with the rights of welfare recipients. In 1969 the United States Supreme Court handed down *Shapiro* v. *Thompson,* 394 U.S. 618 (1969), holding the Connecticut one-year welfare residence requirement unconstitutional, and since 1968, the Supreme Court has issued at least eight other major opinions dealing with welfare rights and related matter. Some form of guaranteed income, negative income tax, or similar social program appears imminent, also, thus reducing the ranks of the truly destitute even further.

situation is the decision of the Nebraska Supreme Court in *Evangelical Luth. Good Samaritan Society* v. *County of Gage*, 181 Neb. 831, 151 N.W.2d 446 (1967), where the tax officials were complaining, as expected, that there was little or no "free" care being provided by the Good Samaritan Society's nursing homes in Nebraska, although a number of welfare patients were being cared for. The Nebraska Court took a realistic, up-dated view of the situation in rejecting the tax official's position:

> " 'Formerly all institutions furnishing services of this nature, including both hospitals and nursing homes, were providing care for many patients without a compensation and extended charity in the sense of almsgiving or free services to the poor. *With the advent of present-day Social Security and welfare programs, this type of charity is not often found because assistance is available to the poor under these programs.*' " *Id.* at 449. (Emphasis added.)

Similarly, in *Ev. Lutheran Good Samaritan Society* v. *Dept. of Revenue*, 5 O.T.R. Ad. Sh. 15 (Ore. Tax Ct. 1972), the Oregon Tax Court dealt with a combined nursing home-convalescent hospital in which the "facility was being paid for its services and the evidence reveals that virtually every patient who was not able to pay his own way was eligible for welfare assistance." Because the nursing home-hospital was being paid for "virtually every patient" the Oregon Revenue Department denied a charitable tax exemption, concluding that "no 'charity,' within the concept of 'almsgiving,' is here involved." *Ev. Lutheran Good Samaritan Society* v. *Dept. of Revenue, supra*, at 21. The Tax Court reversed, noting:

> "A charitable corporation, such as the plaintiff . . ., refusing admission to none for whom there is room, will not lose its charitable status because it serves welfare patients and *no other nonpaying patients apply*." *Id.* at 23. (Emphasis added.)

The Court took cognizance of the modern facts of life—that third party-payor programs such as welfare have largely replaced traditional "almsgiving":

> "(T)oday governmental welfare activities are considered necessary to fill a need which at one time was deemed to be sufficiently met through citizens' contributions to private charities. Where once a charitable hospital or nursing home could subsist by virtue of charges to paying patients plus contributions, todays' recognized needs could not be met without the use of statutory welfare aid." *Id.* at 22, 23. (Emphasis added.)

In a recent North Dakota Supreme Court decision, *Evangelical Lutheran Good Samaritan Society* v. *Board of County Commissioners*, 219 N.W.2d 900 (N.Dak., 1974), involving a nursing home, the facts again showed "no evidence that the Devils Lake Home provided care for *any* resident on a 'free" basis . . .", *Id.* at 903. (Emphasis added). The North Dakota Supreme Court nevertheless granted exemption under a statute exempting property of "charitable institutions" which was "used for public charity". (§57-02-08, N.D C.C.). Acknowledging the long standing *policy* of the Society to care for persons without regard to financial ability, the Court simply took a modern view disposing of the traditional "free care" argument advanced by the tax officials, by observing:

> "In earlier years, before the advent of modern welfare programs, many persons sought *free care* from institutions such as those the Society maintains. However, today welfare programs are widespread *and a matter of right*." *Id.* at 908. (Emphasis added.)

And, the Court concluded:

> ". . . [W]e believe that the better reasoned view in these days of widespread welfare programs is that an institution—which is engaged in the charitable purpose of supplying care and attention to the aged and which institution has always had a policy of supplying this care and attention to all who need its services, regardless of financial ability to pay—does not lose its charitable character because such institution charges fees to those patients who need its services, or because it has *never provided care for a patient on a free basis.*" *Id.* at 909 (Emphasis added.)

The Good Samaritan cases do not stand alone. In fact, the majority of American courts, in cases dealing with tax exemption for hospitals and homes for the aging based on the definition of "charity" or "charitable purpose" choose the broader definition of the term and do not require the provision of free services.[4]

> ". . . [Sickness], pain and suffering are the heritage of all. We are continually attended by peril and may at any time, and when least expected, be stricken by misfortune and affliction. No man can be so rich or so circumstanced as to be exempt from this condition. And, if so overtaken, is charity to withhold its ministrations because the stricken sufferer might not be poor? Is the Samaritan to refuse to bind up the wounds of the unconscious man on the wayside because he may have means to pay a physician? Charity, whether public or private, sees the need, or want, or affliction, or suffering, and its first concern is to bring

4. See, for example, cases cited under Section III of the Argument herein, as well as numerous cases cited by American Hospital Association as Amicus Curiae in its brief submitted in this case.

> relief. The question of whether the recipient is able to pay is the merest incident and of minor importance." *Jackson County Missouri* v. *State Tax Commission,* 521 S.W.2d 378, 382 (Mo. 1975).

II.

Tax Exemption Is Vital to Non-Profit Homes for the Aging As Well As Hospitals, and the Continuation of Their Good Works Depends on the Continuation of Tax-Exempt Charitable Status, Even Though Substantial Fees May Be Charged to Beneficiaries.

The ruling in controversy in the case at bar is *Rev. Rul.* 69-545, 1969-2 Cum. Bull. 117, in which the Internal Revenue Service removed from the conditions for granting hospitals exemption from tax the requirement previously imposed in *Rev. Rul.* 56-185, 1956-1 Cum. Bull. 202, that hospitals not refuse treatment to those unable to pay for it. In an analogous fashion, I.R.S. *Rev. Rul.* 72-124, 1972-1 Cum. Bull. 145, superceded *Rev. Rul.* 57-467, 1957-2 Cum. Bull. 313, thereby permitting homes for the aged to obtain tax-exempt status even though, under certain circumstances, they ordinarily admit only persons able to pay the established rates:

> ". . . [It] is now generally recognized that the aged, apart from considerations of financial distress alone, are also, as a class, highly susceptible to other forms of distress in the sense that they have special needs because of their advanced years. For example, it is recognized in the Congressional declaration of objectives, Older Americans Act of 1965, Public Law 89-73, 89th Congress, 42 U.S.C. 3001, that such needs include suitable housing, physical and mental health care, civic, cultural, and recreational activities, and

an overall environment conducive to dignity and independence, all specially designed to meet the needs of the aged. Satisfaction of these special needs contributes to the prevention and elimination of the causes of the unique forms of "distress" to which the aged, as a class, are highly susceptible and may in the proper context constitute charitable purposes or functions *even though direct financial assistance in the sense of relief of poverty may not be involved.*" (Emphasis added.) *Rev. Rul.* 72-124, 1972-1 Cum. Bull. 145, 146.

Whether a determination of invalidity of *Rev. Rul.* 69-545 in this case would have a direct and immediate effect on exemptions for homes for the aging remains, of course, to be seen. But the developments in the law in both areas are analogous, and the various factors leading to the recognition of charitable status even where fees are charged are quite similar in the two cases—a recognition of the effect of modern social trends on traditional concepts of "charity." A redefinition by this Court of "charity" as regards hospitals would necessarily affect the definition of "charity" as regards homes for the aging.

Tax exemptions do not exist in a legislative vacuum; they are a reflection of vital public policy. For hospitals that policy is the need of health care for everyone. For homes for the aging, it is the protection of interests of our rapidly-growing elderly population through provision of multiple levels of care—health care, housing, financial security, nutritional assistance, and a host of all-important social services—the bolstering of pride and integrity, the support of companionship and kindness in a time fraught with loneliness and isolation—an attempt to preserve the dignity of humanity throughout the aging process, and finally the dying process. Such public policies mandate

that the loss of tax exemption, and the resulting financial burdens on such institutions and their patients and residents, can only lead to an increased *direct* burden on *government*.

Non-profit homes for the aged have traditionally accepted the momentous challenge of this public need; the granting of property tax exemption has enabled church and fraternal groups to provide homes for the aged with a comprehensive living environment and care during sickness at a lower cost than would otherwise be possible. If non-profit homes for the aging were deprived of the encouragement of tax exemption, the financial impact on their programs and residents would be severe, and the societal impact would fly in the face of current but long-overdue national recognition of the depth of the problem of care for our elderly citizens.

"It is a matter of common knowledge that aged people require care and attention apart from financial assistance, and the supply of this care and attention is as much a charitable and benevolent purpose as the relief of their financial wants. Every civilized community must provide facilities, either public or private, for the care of the old people, regardless of financial condition, and a bequest to such an institution to further its purposes is of enough social value to be designated as charitable." *In re Henderson's Estate*, 17 Cal. 2d 853, 112 P.2d 605, 607, 608 (1941).[5]

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5. Also see the numerous cases cited and discussed in Section III below.

III.

The Legal Definition of "Charity" Is the Singularly Most Important Factor in State-by-State Judicial Determinations of Income and Property Tax Exemption for Non-Profit Hospitals and Homes for the Aging, and Prevailing American Law Overwhelmingly Recognizes That the Provision of Free Services by Such Non-Profit Organizations Is Not Required for Charitable Status or Tax Exemption.

State after state has by judicial decision exempted from taxation the property of non-profit hospitals and homes for the aged because they fall within the legal definition of "charity" or "charitable purpose." For the sake of brevity and avoidance of repetition, discussion is omitted on the cases dealing with non-profit hospitals, which are universally granted exemption from ad valorem property taxation because they are "charitable."[6]

A selection of cases from various jurisdictions dealing with non-profit homes for the aged and directly analogous issues are as follow:

ARIZONA: The Court of Appeals of Arizona, in *Memorial Hospital* v. *C. L. Sparks*, 9 Ariz. App. 478, 453 P.2d 989 (1969), held in favor of property tax exemption for senior citizen apartments owned and operated by a hospital (with the Court noting that hospital ownership was not controlling). While annual incomes of residents were generally low, rent payments were required and a qualification for entrance was the ability to make the payment.

---

6. Again, the hospital cases are thoroughly discussed in the Brief for the Secretary of the Treasury, and the Brief of the American Hospital Association as Amicus Curiae, as filed herein.

CALIFORNIA: The California Supreme Court has had numerous opportunities to consider the issue exhaustively, and has repeatedly concluded that non-profit homes for the aged are "exclusively charitable" and entitled to tax exemption, despite the charging of substantial fees for care.

1. *In re Henderson's Estate*, 17 Cal. 2d 853, 112 P.2d 605 (1941), involved a fraternal home for the aged which required its residents to assign all of their assets to the home upon admission:

> "The bequest in the present case was clearly made for a charitable purpose. Since the enactment of the Statute of Charitable Uses during the reign of Elizabeth, aid to the aged and infirm has been recognized as charitable . . . Relief of poverty is not a condition of charitable assistance. If the benefit conferred has a sufficiently widespread social value, a charitable purpose exists." *Id.* at 607.
>
> ". . . aged people require care and attention apart from financial assistance . . ." *Id.* at 608.

2. *Pacific Home* v. *Los Angeles County*, 41 Cal. 2d 844, 264 P.2d 539 (1953): The home, sponsored by the Methodist Church, granted admission on a single-fee life care contract with the entry charge determined by the life expectance of the applicant and the accommodations selected. Approximately $2,000 per year was contributed to a charitable assistance fund for residents; no other instance of financial charitable assistance is cited by the court, but during the tax years in question, the home operated at a loss. On dissolution, the assets were to go to the church. *Held*: The home is exclusively charitable, and its assets are irrevocably dedicated to charity.

3. *Solheim Lutheran Home* v. *County of Los Angeles*, 152 Cal. App. 775, 313 P.2d 185 (1957), in which the court reapplied the holding of *Pacific Home, supra*.

4. *Fifield Manor* v. *County of Los Angeles*, 188 Cal. App. 2d 1, 10 Cal. Rptr. 242 (1961). The county charged that three homes seeking to retain their welfare exemption from property taxation were not charitable because they were "luxury" apartments whose admissions and care fees were beyond the reach of the average person. Charges for life-care were a lump sum based upon cost. The court upheld exemption:

> "Relief of poverty is not a condition of charitable assistance . . . . The concept of the charity is not confined to relief of the needy and destitute, for aged people require care and attention apart from financial assistance, and the supplying of this care and attention is as much a charitable and benevolent purpose as the relief of their financial wants." *Id.* at 249.

The Court went on to say:

> "Any person, the rich as well as the poor, may fall sick or be injured or wounded and become a fit subject for charity. St. Luke, chapter 10, verses 30-37." (Citing *Dingwell* v. *Seymour*, 91 Cal. App. 483, 498, 267 P. 327, 333 (1st Dist. 1928)).
>
> ". . . [I]t seems clear that a home for the aged which caters to wealthy persons and furnishes them those services and care needed by the old and the infirm, rich or poor, does not cease to be a charitable institution so long as its charges do not yield more than the actual costs of operation." 10 Cal. Rptr. at 254.

DELAWARE: In *Electra Arms Apartment and Medical Center Foundation, Inc.* v. *City of Wilmington*, 254 A.2d 244 (Del. Supr., 1969), the Delaware Supreme Court upheld property tax exemption for a complex providing housing and medical services to elderly residents, notwithstanding the charging of rent, apparently to all its residents. The fact that after its large mortgage was paid off the corporate charter could be altered to eliminate the nonprofit dedication was held not to be controlling.

FLORIDA: The Florida Supreme Court has upheld the "exclusively charitable" exemption of a home for the aged—*regardless* of the lack of financial need or even physical or mental infirmity of its residents. *Jasper* v. *Mease Manor, Inc.*, 208 So.2d 821 (Fla. 1968). The *Jasper* case brought the state of Florida firmly in line with the majority American view that, given the pressing need for facilities to care for the aged, they are objects of charity regardless of financial need; thus, nonprofit institutions caring for them are "exclusively charitable" under law.

In fact, Florida legislation passed in 1971 prescribing an "income test"—maximum annual incomes for residents—for determining ad valorem tax exemption for homes for the aged was declared unconstitutional by the Florida Supreme Court. The test was held to be overly restrictive in failing to emphasize the overall purpose or use of the organization. *Presbyterian Homes of the Synod of Florida* v. *Earl K. Wood*, 297 So.2d 556 (Fla. 1974).

GEORGIA: The Georgia Court of Appeals has held in favor of tax exemption for a home for the aged, even though the home had admission restrictions requiring that each incoming resident be ambulatory and pass a medical examination, as well as be financially able.

> "'Charity', as used in tax exemption statutes, is not restricted to the relief of the sick or indigent, but extends to other forms of philanthropy or public beneficence, such as practical enterprises for the good of humanity, operated at moderate cost to the beneficiaries, or enterprises operated for the general improvement and happiness of mankind." *Peachtree on Peachtree Inn, Inc.* v. *J. L. Camp*, 120 Ga. App. 403, 170 S.E.2d 709, 714 (1969).

This position was affirmed in *Central Board on Care of Jewish Aged, Inc.* v. *Henson*, 120 Ga. App. 627, 171 S.E.2d 747 (1969), a case involving a home which, in addition to health and financial entrance requirements, restricted membership to people of the Jewish faith; the Court again held in favor of tax exemption:

> "The concept of charity is not confined to the relief of the needy and destitute, for 'aged people require care and attention apart from financial assistance, and the supply of this care and attention is as much a charitable and benevolent purpose as the relief of their financial wants.'" *Id.* at 750, citing *Bozeman Deaconess Foundation* v. *Ford*, 151 Mont. 143, 439 P.2d 915 (1968).

INDIANA: The Appellate Court of Indiana held that a retirement home operated by a non-profit organization which provided for full care of its aged occupants and devoted all income, after payment of expenses, to purposes of maintaining the home, was entitled to total exemption from property taxes. *State Bd. of Tax Comm'rs* v. *Methodist Home for the Aged*, 143 Ind. App. 419, 241 N.E.2d 84 (1968).

MARYLAND: In an old case—still recognized as good law—the Maryland Supreme Court did not question the

charitable nature of a home requiring an entrance fee and a conveyance of all property of the applicant. The issue arose in a suit brought by the home to recover assets from the estate of a resident who had concealed property. The court noted:

> ". . . [T]his and similar charities are directly within the line of a sound and humane public policy. They do not only tend to relieve suffering in the individual, but tend to keep them from being a charge upon the general public. For this purpose money is necessary . . . ." *German Aged People's Home* v. *Hammerbacker*, 64 Md. 595, 3 A. 678, 680 (1886).

In a much more recent case, the Maryland tax court upheld the position:

> "Here we have a corporation devoted to improving the living conditions of older people. It is clear that the relief of the aged is a charitable purpose. (Statute of Elizabeth, 13 Eliz. Ch. 4, 1001).
>
> "We cannot agree that to give a person something at cost is not an act of charity . . . ." *Department of Assessments of Baltimore City* v. *St. Mary's Roland View Towers, Inc.* (Maryland Tax Court, City App. #320 and #397, August 25, 1965).

MASSACHUSETTS: In a 1938 case before the Supreme Judicial Court of Massachusetts, the "charitable character" of a nonprofit home for the aged was at issue. Testator left funds to an existing nonprofit home for the aged, to be used to finance a new building for the home; another beneficiary challenged the bequest, in part, on the basis that it was not properly charitable. The Fisher Home had six or seven residents, *all* of whom had contributed funds to the home, aggregating $14,000. Earlier

residents had contributed $50,000, and those gifts constituted the treasury of the corporation, producing about $3,000 income a year. An additional $800 a year was contributed by another charitable corporation. Held: The fact of contributions by residents "does not deprive the corporation of its charitable character." *Old Colony Trust Co.* v. *O. M. Fisher Home,* 301 Mass. 1, 16 N.E.2d 10, 11 (1938).

MINNESOTA: In a case involving a nursing home, the Minnesota Supreme Court held in favor of tax exemption because the home was dedicated to the charitable purpose of care for the aging, notwithstanding charges to beneficiaries and a "profitable" operation:

> "Thus, in *Christian Business Men's Committee of Minneapolis, Inc.* v. *State,* 228 Minn. 549, 555, 38 N.W.2d 803, 809 (1949), the words 'purely public charity' were referred to as follows:
>
> "* * * The word 'purely' means 'wholly', and 'solely,' and 'exclusively' in such exemption provisions and qualifies the use that may be made of the institution's property. *State* v. *Willmar Hospital, Inc.,* 212 Minn. 38, 41, 2 N.W.2d 564, 566 (1942). What is meant by a purely or exclusively charitable use of property is a direct, immediate, and actual application of the property itself to the purposes for which the charitable institution is organized. It is the direct and immediate use of the property, and not the use of the income therefrom, that is determinative of whether the property is used for tax-exempt purposes.
>
> "Nor does the fact that an organization claiming exemption as one of 'purely public charity' operates at a profit derived from charges made to its patients

> nullify its status as an institution of 'purely public charity' if under its charter its operations are intended for the benefit of the public generally and thereunder none of such profits can be paid to stockholders or others." *Assembly Homes, Inc.* v. *Yellow Medicine Co.,* 273 Minn. 197, 140 N.W.2d 336, 340 (1966).

MONTANA: In an often-cited opinion, the Montana Supreme Court squarely joined the majority position. *Bozeman Deaconess Foundation* v. *Ford,* 151 Mont. 143, 439 P.2d 915 (1968). In that case, the home, built at a cost of approximately $2,000,000, required the payment of life-care occupancy fees ranging from $7,000 to $32,000 and monthly maintenance charges of from $150 to $250. The home was open to applicants without regard to race or religion, the only requirements being that the applicant be at least 62 years old, or married to someone 62 or older. The court held that the home was an "institution of purely public charity," and fully exempt from property taxation under state law. Upholding the majority view, the court stated:

> "It may be that appellants [tax officials] feel the standard of care, the excellence of accommodations and the mode of life accorded by this facility, all reflected by the size of the occupancy and maintenance fees, and the physical plant and facilities are inconsistent with the usual concept of charity. But 'charity' to the law has a much broader meaning than that accorded it in common speech. (15 Am. Jur. 2d, p. 8.) The scope of charity and the standards under which it is administered are not frozen by the past, but keep pace with the times and the new conditions and wants of society. (Zollman, American Law of Charities, pp. 121, 123)." *Id.* at 918.

NEBRASKA: The Supreme Court of Nebraska has held to a strict line of denying exemption to so-called "homes for the aged" which provided *only* housing for the elderly. See *Christian Retirement Homes, Inc.* v. *Board of Equalization of County of Lancaster,* 186 Neb. 11, 180 N.W. 2d 136 (1970) and *OEA Senior Citizens, Inc.* v. *County of Douglas,* 186 Neb. 593, 185 N.W.2d 464 (1971).

However, tax exemption is granted where a wider range of services is provided:

> "Charity is defined as being something more than mere almsgiving or the relief of poverty and distress, and it has been given a significance broad enough to include practical enterprises for the good of humanity operated at a moderate cost to those who receive the benefits." *Evangelical Lutheran Good Samaritan Society* v. *County of Gage,* 181 Neb. 831, 151 N.W.2d 446, 447 (1967).

NEW YORK: Two New York cases have exempted nonprofit homes for the aged which made charges to residents:

1. *In re Vassar's Estate,* 127 N.Y. 1, 27 N.E. 394 (1891). The case involved the inheritance tax exemption of a bequest to the Vassar Brothers Home for Aged Men in Poughkeepsie, New York. Upon entering the home, all residents paid $250.00 as an entrance fee, or somewhat less if they were of advanced age. In addition, they were required to transfer all property they might have to the home. Held: The charges do not deprive the institution of tax exempt status as a charity.

2. *American-Russian Aid Association* v. *City of Glen Cove,* 41 Misc. 2d 622, 246 N.Y.S. 2d 123 (1963). The home consisted of five residences, housing a total of 45 or 50 aged

persons, "unable to work, although ambulatory and reasonably able to care for themselves." Some residents were on welfare, but many were apparently subsidized by relatives with funds. An "annual recurring deficit" was experienced by the home. Held: Except as "exclusively charitable." The room rent "does not cancel the stamp of charity. Profits do not accrue; the rents received aid the plaintiff in carrying out its beneficent objectives." *Id.* at 127.

OHIO: In *Carmelite Sisters, St. Rita's Home* v. *Board of Review,* 18 Ohio St. 2d 41, 247 N.E.2d 477 (1969), the question was whether the nonprofit home for the aged was liable to contribute to the state unemployment compensation fund, rather than tax exemption. The issue, however, was the same: Were the home's activities "confined exclusively to rendition of service for charitable purposes?" The Court held that it was, even though residents paid all or a large part of the cost of their upkeep.

OREGON: In the case of *Ev. Lutheran Good Samaritan Society* v. *Department of Revenue,* 5 O.T.R. Ad. Sh. 15 (Ore. Tax Ct. 1972), the Oregon Tax Court held in favor of exemption for plaintiff's nursing home facility, even though some payments were received for services to all its residents, either directly or through welfare payments by the State.

PENNSYLVANIA: The Supreme Court of Pennsylvania allied itself squarely with the prevailing view that nonprofit care of the aged is a "purely public charity." *In re Tax Appeals of the United Presbyterian Homes of the Presbytery of Huntingdon,* 428 Pa. 145, 236 A.2d 776 (1968). The home in question was similar to other homes for the aged exempted from property taxation in the cases set forth herein. The home was largely self-supporting, mainly by

payment from residents. Tax authorities argued that this destroyed its qualification for exemption, but the court disagreed:

> "To adopt this argument of the appellants would require us to hold that whenever a nonprofit institution made a charge for its care or services to any resident or patient, the institution would be precluded from obtaining tax exemption. Consequently, hospitals which charge large sums for the care of and services to paying patients, and colleges, and universities which charge tuition to countless students, would not be entitled to real estate tax exemption. This interpretation and result is not required by the language or spirit of the Constitution of Pennsylvania or of the legislation pertaining to tax exemption." *Id.* at 780.

TEXAS: The Supreme Court of Texas will soon decide an appeal on the tax-exempt status of a nursing home facility. An appellate court held in favor of exemption, notwithstanding the fact that payments were made for most residents—if not directly, through third-party welfare sources. *City of McAllen* v. *Ev. Lutheran Good Samaritan Society*, 518 S.W.2d 557 (Tex. Civ. App. 1975).

WISCONSIN: *Milwaukee Protestant Home for the Aged* v. *City of Milwaukee*, 41 Wis. 2d 284, 164 N.W.2d 289 (1969) involved a home for the aged with a thirty-four (34) bed nursing home. Residents were charged, in 1969, entrance endowments (up to $15,500.00) and monthly fees ($150.00 to $160.00). The Wisconsin Supreme Court held that the home involved was operating as a public charity:

> "In the minds of some, the phrase objects of charity still conjures up a soup kitchen picture of penniless drifters lined up outside a skid row mission.

> Concern for the plight of the entirely destitute has its proper place, but the word benevolent has no in-built implication or requirement of alms-giving. To help retired persons of moderate means live out their remaining years is benevolent whether or not it is also considered, as we would consider it to be 'charitable'." *Milwaukee Protestant Homes, supra,* at pp. 296-297.
>
> ". . . [W]e conclude that the property of the Milwaukee Protestant Home for the Aged, including the Bradford Terrace Addition and its convalescent center, is exempt from property taxation. . . ." *Id.* at 298.

FEDERAL: The only Federal case dealing directly with the question of whether a health-care institution may charge its beneficiaries and still retain its income-tax exemption is one which predates both *Rev. Rul.* 69-545 relating to hospitals and *Rev. Rul.* 72-124 relating to homes for the aged. *Salem Lutheran Home* v. *Comm'r,* 2 T.C.M. 157 (1943). In that case, only a few "residents had ever been admitted without charge," and those "only temporarily." An endowment fund had been established for the purpose of helping indigent residents, but it was "not yet sufficient for any extensive use." During fourteen years of operation, donations to the home amounted to only $18,-000.00. The Internal Revenue Service claimed that the home was not "exclusively charitable" and that it should not be exempted from federal taxes. Held: Exclusively charitable and tax-exempt:

> "In other words, is the operation of a home for the care and comfort of aged persons, without profit to any individual and from purely religious or philanthropic motives, a charity within the intendment of the statute? We think that it is.

"It does not operate for the benefit of any select group of individuals or institutions. The fact that it is necessary for petitioner to charge a substantial admission fee in order to carry on its work does not deprive it of the status of a tax exempt corporation." *Id.* at 159.

CONCLUSION

For the above reasons, together with those argued by the Secretary of the Treasury and the American Hospital Association as *amicus curiae* in their respective briefs filed herein, *Rev. Rul.* 69-545 is consistent with Section 501(c)(3) of the Internal Revenue Code; therefore the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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DEC 1

In the Supreme Court of the United States

OCTOBER TERM, 1975

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,
Petitioners
v.
WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,
Respondents

No. 74-1124

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,
Petitioners
v.
EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION,
Respondents

On Certiorari to the United States Court of Appeals for the District of Columbia Circuit

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REPLY BRIEF FOR THE PETITIONERS IN 74-1110

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In the Supreme Court of the United States

OCTOBER TERM, 1975

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,
Petitioners

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,
Respondents

No. 74-1124

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,
Petitioners

v.

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION,
Respondents

On Certiorari to the United States Court of Appeals for the District of Columbia Circuit

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REPLY BRIEF FOR THE PETITIONERS IN 74-1110

I. NON-TAXPAYERS MAY SEEK JUDICIAL REVIEW OF IRS RULINGS.

1. Defendants' primary contention is that non-taxpayers cannot seek review of IRS rulings even without regard to the Anti-Injunction Act, 26 U.S.C. § 7421(a)

(Def. Br. 27-48). Defendants' arguments against reviewability, however, portray a profound misunderstanding of administrative law.

In essence, defendants posit three reasons why nontaxpayers should not be permitted to seek review of IRS rulings absent express statutory authority. First, Congress has given the Secretary of the Treasury, as opposed to all other government officials, extensive authority in the areas of rulings and refunds (Def. Br. 35-42). Second, Congress has given the Secretary and the Commissioner the power to prescribe "all needful rules and regulations" for the enforcement of the Internal Revenue Code (Def. Br. 38). Third, the Secretary and the Commissioner have special expertise in carrying out this "discretionary rule-making responsibility" (Def. Br. 38-39).

The difficulty with defendants' position is that virtually every federal agency could make the same arguments in favor of non-reviewability. Virtually every agency has tasks for which it, and no other part of the executive branch, is solely responsible.[1] Virtually every agency with regulatory authority has been provided by Congress with the power to make all necessary rules and regulations.[2] And, of course, every agency can legitimately lay claim to expertise in its particular field.

[1] Defendants argue that *a fortiori* private parties cannot set aside the actions of the Commissioner because under section 6406 no other administrative or accounting officer of the United States can set aside his actions (Def. Br. 41-42). There is nothing *a fortiori* about it. The fact that Congress gives one executive official final authority within the government over a matter does not mean that private parties cannot seek judicial review of the official's actions.

[2] *See, e.g.*, 15 U.S.C. § 46(g) (Federal Trade Commission); 29 U.S.C. § 657 (Secretary of Labor under the Occupational Health and Safety Act); 33 U.S.C. § 1172(a) (Secretary of Interior under the Water Pollution Control Act); 46 U.S.C. § 876(i) (Secretary of Commerce under the Merchant Marine Act); 47 U.S.C. § 303(f) (Federal Trade Commission).

Under defendants' reasoning, therefore, agency actions would never be reviewable absent an express statutory provision. But such reasoning turns administrative law on its head. Judicial review of administrative action is the rule, and non-reviewability is the exception which requires congressional approval.[3]

Defendants appear to be confused about the most basic tenets of administrative law. They stress "the constitutional and statutory commitment to vest the administration of the revenue law exclusively in the Executive Branch" (Def. Br. 44). But the administration of *all* laws rests exclusively in the executive branch. Judicial review of agency action is not tantamount to administration of the laws, whether they be revenue laws, securities laws or drug laws. Courts are not administering the laws when they seek to assure that the executive branch is complying with congressional mandates.

In effect, defendants seek to amend the judicial review provisions of the Administrative Procedure Act to secure an exemption for the IRS. But only Congress can provide such an exemption. The Court should make clear that the IRS is bound by the Administrative Procedure Act.

2. Defendants seek to buttress their attack on reviewability with several inaccurate assertions. First, defendants assert that plaintiffs seek retroactive revocation of a revenue ruling and that such revocations would create widespread uncertainty (Def. Br. 34-35). But, of course, plaintiffs have no interest whatsoever in retroactive revocation of Revenue Ruling 69-545. Plaintiffs are concerned with the future conduct of non-profit hospitals, not with past tax liabilities.

[3] *See, e.g., Barlow* v. *Collins*, 397 U.S. 159, 166-167 (1970); *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 141 (1967); *Rusk* v. *Cort*, 369 U.S. 367, 379-80 (1962).

More generally, the IRS would be as free to revoke rulings prospectively after successful suits by non-taxpayers as it is after successful suits by taxpayers. Thus, non-taxpayer suits would not increase uncertainty. Indeed, far more uncertainty is created by the massive number of taxpayer suits than would be created by the rare non-taxpayer suit.[4] In short, defendants' retroactivity argument is baseless.

Defendants also assert that litigation such as plaintiffs' could be used to compel the IRS to audit a particular taxpayer or to impose a heavier tax burden on a competitor (Def. Br. 44). This is obviously untrue. Plaintiffs do not and could not seek to compel the IRS to take action against any particular taxpayer.[5] They do not and could not seek to establish priorities for the IRS in the enforcement of the tax laws. Plaintiffs simply seek invalidation of a general ruling in the expectation that under our "self-reporting tax system" (Def. Br. 30) invalidation of the ruling will itself alter hospital conduct. It will be up to the IRS and the IRS alone to determine how much resources to devote to assuring that particular hospitals comply with a valid revenue ruling. Thus, this litigation does not derogate from the IRS' "prosecutorial discretion."

Finally, defendants suggest that the jurisdictional holdings of the Court of Appeals would jeopardize the letter rulings program by inviting anyone who disagreed with

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[4] Taxpayer suits often overturn IRS rulings and even regulations. See, *e.g.*, *United States* v. *Cartwright*, 411 U.S. 546 (1973).

[5] The relief which was accorded to plaintiffs by the District Court was the invalidation of Revenue Ruling 69-545 and a requirement that defendants direct tax-exempt hospitals to post notification of "free service." This relief does not require defendants to prosecute anyone. Although the Complaint also requested an order compelling defendants to collect taxes due and owing from hospitals which refused to serve the poor, that relief was not ordered, and plaintiffs did not seek such relief on appeal.

a letter ruling to sue (Def. Br. 34-35). But the number of letter rulings which might be challenged by non-taxpayers is miniscule. A suit involving letter rulings is infinitely more likely to come from a taxpayer who brings a refund suit seeking the same favorable ruling a competitor received. See, *e.g.*, *IBM* v. *United States*, 343 F.2d 914 (Ct.Cl. 1965), *cert. denied*, 382 U.S. 1028 (1966).

Defendants' attempts to broaden the reach of the Anti-Injunction Act are without merit. Defendants argue that the Anti-Injunction Act bars judicial interference "with the *process* of collecting" taxes (Def. Br. 61, emphasis in original), and that the "process" of tax collection includes promulgation of the revenue ruling at issue here. This argument proves too much. Any suit against the IRS, including suits challenging the agency's employment policies or its domestic surveillance policies, can be said to interfere with the "process" of collecting taxes. But, surely, such suits are not barred by the Anti-Injunction Act.

Defendants argue once again that challenges to revenue rulings might curtail the agency's activities "in other, more fruitful areas of enforcement, . . . to the detriment of the revenue collections" (Def. Br. 62). But as plaintiffs have already noted, p. 4 *supra*, their suit does not require the IRS to alter its enforcement priorities, but leaves the IRS free to deploy its enforcement resources in any rational manner it chooses.

Finally, defendants claim that it would be anomalous for Congress to permit this suit when it bars injunctive actions by taxpayers (Def. Br. 63). But Congress has provided taxpayers with other judicial remedies. It is not anomalous for Congress to provide some means of judicial review for all aggrieved persons, taxpayers and non-taxpayers alike.

4. Defendants argue that the tax exception to the Declaratory Judgment Act, 28 U.S.C. § 2201, is broader than the Anti-Injunction Act (Def. Br. 63). But defendants fail to suggest why Congress would bar declaratory relief in situations where it did not bar injunctive relief.[6] And, significantly, defendants do not even attempt to argue that the Declaratory Judgment Act somehow broadened the Anti-Injunction Act. (See discussion in plaintiffs' principal brief, 53-56).

5. Defendants assert that the doctrine of sovereign immunity applies because plaintiffs do not complain that the Secretary or the Commissioner acted beyond their statutory powers (Def. Br. 73). This is incorrect. Plaintiffs do complain that it is beyond the defendants' statutory powers to promulgate Revenue Ruling 69-545 without following the Administrative Procedure Act and without adhering to Section 501(c)(3) of the Internal Revenue Code.

Defendants fail to confront plaintiffs' Administrative Procedure Act claim at all. With respect to plaintiffs' Section 501(c)(3) claim, defendants imply that when the Commissioner erroneously interprets a term of the statute and acts upon that interpretation, he is not acting beyond his statuory powers (Def. Br. 73). Under this reasoning, the Commissioner would not be acting beyond his statutory powers if he granted a charitable exemption to General Motors; he would simply be making an erroneous interpretation of the statute. Defendants are advancing an erroneous interpretation of the sovereign immunity doctrine.

6. The common thread that runs through all of defendants' jurisdictional points is that non-taxpayer challenges to rulings would disrupt the IRS and burden the

[6] There may be situations where declaratory relief is permitted even though injunctive relief is barred. *See, e.g., Steffel* v. *Thompson*, 415 U.S. 452 (1974).

courts. But, as plaintiffs have emphasized, the number of non-taxpayer suits is miniscule compared to the massive number of taxpayer suits with which IRS and the courts must cope. In fiscal year 1975 over 12,500 tax suits were filed in federal district courts, the Tax Court and the Court of Claims.[7] By contrast, defendants can point to only 15 non-taxpayer suits filed in the last five fiscal years (Def. Br. 47 n. 79). Defendants are straining at gnats while swallowing camels.

II. PLAINTIFFS HAVE STANDING TO SEEK JUDICIAL RELIEF FOR THE DEFENDANTS' VIOLATIONS OF LAW.

The District Court and the Court of Appeals correctly held that plaintiffs have standing to seek judicial resolution of the violations with which they charge defendants (Pl. Pet. 38a-48a, 12a n. 6). The defendants contend otherwise in this Court. They claim that plaintiffs are seeking review of a prosecutorial decision (Def. Br. 50-53). They also contend that plaintiffs lack standing under this Court's "zone of interest" and "injury in fact" tests for standing (Def. Br. 53-57). All three contentions are incorrect.

(A) Plaintiffs are not seeking review of a prosecutorial decision.

Defendants rely on the decision in *Linda R.S.* v. *Richard D.*, 410 U.S. 614 (1973), in which this Court held that "a private citizen lacks a judicially cognizable interest in the prosecution or non-prosecution of another." 410 U.S. at 618. But defendants' reliance on *Linda R.S.* is misplaced. The Court in *Linda R.S.* emphasized that

[7] These statistics were obtained through telephone conversations with personnel at the Information Systems Division of the Administrative Office of the United States Courts, the Clerk's Office of the Court of Claims and the Statistics Division of the Tax Court.

its holding on standing occurred "in the unique context of a challenge to a criminal statute." 410 U.S. at 617. The Court spoke of the "special status of criminal prosecutions in our system." *Ibid.* It implied that plaintiff would have had standing to compel initiation of a civil contempt proceeding.[8]

The instant case does not involve a criminal prosecution. More significantly, as discussed above, pp. 4-5 *supra*, it does not involve prosecutorial discretion at all.

(B) Plaintiffs satisfy the "zone of interest" and "injury in fact" tests.

Plaintiffs are seeking judicial resolution of claims that defendants deprived them of their rights under two federal statutes: the charitable provisions of the Internal Revenue Code (26 U.S.C. § 501(c)(3) and § 170(a)-(c)); and the requirements for rulemaking under the Administrative Procedure Act (5 U.S.C. § 553). A long line of recent decisions recognize the standing of persons, arguably within the zone of interests of federal legislation, to sue for a deprivation of statutory rights. Such persons are aggrieved parties within the meaning of § 10 of the Administrative Procedure Act and have been conferred standing by Congress.[9]

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[8] The Court more recently drew a distinct line between an action to compel a criminal prosecution (such as in *Linda R.S.*) and an action to require agency performance of duties owed to individual citizens under civil statutes, albeit governmental interests are also necessarily involved. *Dunlop* v. *Bachowski*, —— U.S. ——, 95 S.Ct. 1851 (1975), affirming the holding of the Court of Appeals on this point quite explicitly (at n. 7).

[9] See, *e.g.*, *Abbott Laboratories* v. *Gardner*, 387 U.S. 136 (1967); *Association of Data Processing Service Organizations* v. *Camp*, 397 U.S. 150 (1970); *Barlow* v. *Collins*, 397 U.S. 159 (1970); *United States* v. *S.C.R.A.P.*, 412 U.S. 669 (1973); *cf. Trafficante* v. *Metropolitan Life Insurance Co.*, 409 U.S. 205 (1972).

Zone of Interests

The Complaint alleges that individual plaintiffs and members of organizational plaintiffs are poor persons, with incomes below the poverty guidelines, suffering from medical conditions requiring hospital services but lacking the means to pay for such services (A. 12-14).[10] Suing on behalf of themselves or their members, and all other persons in similiar circumstances, they claim that they are intended to be protected by, and are beneficiaries of, the "charitable" provisions of the Internal Revenue Code (A. 13).

Poor people needing hospital services but lacking the means to pay are clearly within the zone of interests of legislation conferring special benefits upon hospitals as "charitable organizations." A primary purpose of section 501(c)(3) charitable exemptions is to encourage private efforts to assist the poor. Indeed, defendants' own regulation defines "charitable" in the first instance as "relief of the poor and distressed or of the underprivileged." 26 CFR 1.501(c)(3)-(1)(d)-(2).

Defendants contend that "no provision of the Internal Revenue Code creates . . . a private right of action or a protectable zone of interests" (Def. Br. 56 n. 31). But the decisions of this Court do not require a specific statutory authorization. Rather, the language of the statute and/or its legislative history is construed to determine whether Congress intended, explicitly or implicitly, that certain persons be protected or benefitted by the legislation. Plaintiffs were meant to be benefitted by section 501(c)(3) and thus are within its zone of interests.

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[10] Other allegations give specific circumstances surrounding plaintiffs' economic status, their medical problems, and unsuccessful attempts to obtain hospital services (A. 17-24). Affidavits supplied by them and others, including physicians serving the poor, further amplify their individual situations (A. 78-144).

Plaintiffs are also within the zone of interests of the rulemaking requirements of the Administrative Procedure Act (5 U.S.C. § 553).[11] Persons who may be adversely affected by an agency rule are entitled to have the agency promulgate the rule in accordance with the procedures Congress determined would be fair.[12] Since plaintiffs may be adversely affected by Revenue Ruling 69-545, they are intended beneficiaries of section 553 and are within its zone of interests.

Injury in Fact

Defendants contest the findings of the District Court and the Court of Appeals that plaintiffs have been injured in fact by the deprivation of their statutory rights. In advancing this contention, defendants assert that here is no correlation between the Treasury ruling and either the injuries which plaintiffs have suffered or the relief which plaintiffs would hope to receive from a favorable judicial order. This is incorrect.

Plaintiffs are poor people who have attempted to receive and have been expressly denied necessary hospital care because they could not afford to pay.[13] Under the

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[11] Defendants do not discuss plaintiffs' standing to raise the deprivation of their rights under the rulemaking requirements of the Administrative Procedure Act.

[12] As recognized by this Court in *NLRB* v. *Wyman-Gordon*, 394 U.S. 759, 764 (1969): "The rulemaking provisions . . . were designed to assure fairness and mature consideration of rules of general application" (plurality opinion).

[13] For example, in January 1971 plaintiff Artie Tackett, who had suffered two heart attacks, attempted to get admitted to Prestonburg General Hospital (a non-profit hospital in Floyd County, Kentucky, accorded 501(c)(3) status by defendants). When the Tacketts told the nurse that they did not have the $50 requested for admission deposit, the nurse tore up the admission application (A 81, 82). In June 1971 representatives of plaintiff Eastern Kentucky Welfare Rights Organization, on behalf of their indigent members, met with officials of the Pikesville Methodist Hospital,

prior revenue ruling, hospitals would have been required to afford poor people free care as a condition of retaining tax-exempt status. In order to retain the tax-exempt status, the hospitals would have provided free care to plaintiffs and others similarly situated.[14]

Pike County, Kentucky (another non-profit hospital accorded 501(c)(3) status by defendants) to discuss hospital admission policies. They were flatly told that if their members do not have the money, they do not get in (A 79-80). Plaintiffs Cook, Lampton and Hunter have all been told by admitting personnel at various non-profit 501(c)(3) hospitals in the New Orleans area that they do not serve persons unable to pay (A 99, 104, 113).

Defendants suggest that a closer examination of plaintiffs' affidavits reveals a number of refusals to admit Medicaid beneficiaries, and that Revenue Ruling 69-545 requires that non-profit hospitals admit patients whose care will be paid "with the aid of public programs such as Medicare" (Def. Br. 54 n. 30). But defendants do not understand the workings of the Medicaid program. As plaintiffs have already discussed in their principal brief, Medicaid is a federal-state program, and eligibility is determined on the basis of state criteria, which severely limit the income levels for eligibility as well as services provided. While plaintiff Hunter was eligible for Medicaid in June 1970, when she first attempted to gain admission into 501(c)(3) hospitals which refused to treat the poor (A 104), a slight increase in her income by January 1973 (A 91) made her and her four children ineligible; Louisiana cuts off eligibility for a family of four with an income above $1464 a year (See Pl. Pet. 78a). Two of her children have acute sickle cell anemia (A 91) but cannot obtain services from the New Orleans non-profit hospitals. Further, Louisiana has a fifteen-day limitation for hospitalization, so that persons such as plaintiffs Cook and Lampton (even if still eligible for Medicaid) lose Medicaid coverage once they have exhausted the fifteen days each year (CCH Medicare & Medicaid Guide ¶ 15,592), and plaintiff Cook's illnesses have required more than fifteen days' hospitalization (A 90).

[14] Plaintiffs, of course, are not required to demonstrate that they, as opposed to other poor people in their local hospitals' service areas, would definitely have received free care under the prior ruling. It suffices that they are in the class of people who would receive free care. Similarly, a black person who challenges discrimination in employment need not demonstrate that he, as opposed to all other applicants, would have gotten the job at issue; he merely has to show that he was one of the qualified persons the employer should have considered.

Defendants suggest that plaintiffs would not be better off under the old revenue ruling because hospitals might well forgo their tax-exempt status rather than provide free care, particularly since private philanthropy has declined to only four percent of hospital revenue (Def. Br. 55). Defendants' speculations are unfounded. Defendants ignore the fact that 60 per cent of hospital construction and modernization monies have their origin in "charitable" contributions.[15] The American Hospital Association itself has emphasized how important charitable contributions are to non-profit hospitals.[16] Further, as pointed out by *Amicus* Jackson County, Missouri, Revenue Ruling 69-545 serves as an important criterion for states and their subdivisions in determining local tax exemptions. (Jackson Br. p. 8). Hospitals are not

[15] For example, in 1969, the year in which defendants issued revenue ruling 69-545, $1.5 billion in charitable contributions were made to hospitals for construction or modernization, and this $1.5 billion represented 60% of the total $2.5 billion spent on construction that year. See Hearings on Medicare and Medicaid before the Subcomm. of Medicare-Medicaid of the Senate Comm. on Finance, 91st Cong. 1st Sess., p. 422 (1969).

[16] The President of the American Hospital Association, in testimony before the House Ways and Means Committee, stated:

> "I appear today to express to the committee our concern with any action the committee might take, in connection with its current consideration of tax reform, which could jeopardize or in any way inhibit charitable contributions to the Nation's voluntary nonprofit hospitals. . . . Voluntary nonprofit hospitals are, in varying degrees, dependent upon charitable contributions. . . . A basic incentive to the donations spelled out in the IRS Code are benefits and income tax deductions which have been granted by the States since the inception of the Republic and by the Federal Government following the enactment of the Federal income tax laws. . . . We also believe strongly that existing tax preferences for such donations are the single most important incentive for people to continue to support charitable enterprises." Statement of John Alexander McMahon, President, American Hospital Association, Public Hearings on General Tax Reform, before the Committee on Ways and Means, House of Rep., 93rd Cong., 1st Sess., April 13, 1973, pp. 6349-50.

likely to give up their property tax exemptions and pay hundreds of thousands (or millions) of dollars of tax revenue to states, counties, and municipalities.

Defendants also argue that nothing in the prior revenue ruling "would prevent a private hospital from using its surplus funds for research or capital expenditures rather than for admission of the indigent." (Def. Br. 54-55). This is simply an incorrect reading of Revenue Ruling 56-185, which states that a hospital

> ". . . must be operated to the extent of its financial ability for those not able to pay for the services rendered and *not exclusively for those who are able and expected to pay*. . . . It may also set aside earnings which it uses for improvements and additions to hospital facilities. *It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services.*" (Pl. Br. 7a-8a. Emphasis added)

In short, under the prior ruling, hospitals did have to serve the poor.[17]

Warth v. *Seldin*, —— U.S. ——, 95 S.Ct. 2197 (1975), relied on by defendants, is inapposite here. In *Warth* the Court concluded that "petitioners' description of their individual financial situations and housing needs suggests . . . that their inability to reside in Penfield is the

[17] That the prior ruling in fact forced hospitals to afford free care is demonstrated by the American Hospital Association's strenuous efforts to eliminate the free care requirement through legislation (see plaintiffs' principal brief 25-26). One of the reasons AHA gave for its proposal before the House Ways and Means Committee was alleged harrassment by IRS of hospitals for not giving enough free care. (Hearings on Tax Reform Act of 1969, H.R. 13270, before the House Committee on Ways and Means, 91st Cong., 1st Sess. 1425, 1429, 1438 (1969)). In the summer of 1969, shortly before Revenue Ruling 69-545 issued, such efforts by IRS local officials in Ohio precipitated the *Harding Hospital* case. (See *Harding Hospital, Inc.* v. *United States*, 358 F.Supp. 805, 806 (S.D. Ohio 1973), *aff'd*, 505 F.2d 1068 (6th Cir. 1974).

consequence of the economics of the area housing market, rather than of respondents' assertedly illegal acts." 95 S.Ct. at 2209. By contrast, plaintiffs here contend that a primary purpose of the charitable exemption policy of sections 501(c)(3) and 170 is to ameliorate the economic rigors of the marketplace and that defendants' illegal actions deprive them of the benefits of that policy.

III. NON-PROFIT HOSPITALS MUST SERVE THE POOR AS WELL AS THE RICH IN ORDER TO RETAIN THEIR "CHARITABLE" STATUS UNDER THE CODE.

Plaintiffs' basic contention is that the defendants violated the Internal Revenue Code when they eliminated the requirement that hospitals must serve the poor as well as the rich in order to retain their "charitable" status under the Code (Pl. Br. 14-39). Defendants, while acknowledging that "service to the poor" was given more emphasis in the Treasury's initial administration of the "charitable standard" for hospitals (Def. Br. 88), justify their departure from the prior rule on four grounds: (1) that the current Treasury regulation permits them to eliminate the requirement, and in effect recognize non-profit health organizations as charitable *per se* (Def. Br. 83-84); (2) that the "generally accepted legal sense" of the application of charitable to hospitals under state law has evolved away from the "poor as well as the rich" requirement (Def. Br. 86); (3) that social and economic changes support the elimination of the free service requirement in favor of a policy of general service to all who can pay, and only emergency room service to the poor (Def. Br. 92-95); (4) that the prior rule was administratively unworkable (Def. Br. 95-96). In all respects defendants are mistaken.

1. As demonstrated in plaintiffs' principal brief, there is nothing in the 1969 Treasury regulation or in its

published history to indicate that anyone contemplated elimination of the requirement that charitable institutions must either serve only the poor or must provide services to the entire relevant community, rich and poor alike [18] (Pl. Br. 17-18). Except with respect to hospitals, defendants themselves continue to insist that charitable organizations serve the poor either exclusively or along with respect of the relevant community. Every one of the innumerable organizations which are the subject of the revenue rulings cited by defendants (Def. Br. 90, n. 55) and the American Hospital Association (AHA Br. 20, n. 19; 33-34, n. 34) in fact provide service to the relevant community without regard to ability to pay or else fit into one of the other specific classifications set forth in section 501(c)(3).[19]

Defendants suggest that the exception for hospitals is justified because promotion of health care is recognized as an accepted charitable activity (Def. Br. 87 n. 52). But that statement is an oversimplification. Health care in this country is promoted by individuals and institutions which are most assuredly not charitable. For the most part the public relies for its health care services on private practitioners whose income comes from the fees they collect from each of their patients. The drug

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[18] Plaintiffs use the term "relevant community" because it is clear that charitable institutions can serve specific segments of the community, *e.g.*, children, the elderly, drug addicts, etc.

[19] Reference to all the cited rulings reveals that either the ruling on its face makes it clear that the service is provided to all persons, rich and poor, or the service is provided solely to the poor, is educational (IRS has always characterized theater, music, and art programs under the educational category), protects animals, or promotes public safety. The only possible exception is a 1972 ruling involving homes for the aged (Rev. Ruling 72-124). But even this ruling recognizes that a charitable home must provide "financial security" to the elderly and suggests that rates below customary charges may be necessary for at least some of the residents (1972-1 Cum. Bull. 145).

industry, an integral part of the healing process, is big business. Most non-profit hospitals, like for-profit hospitals, do not have their own medical staffs but rely on and generate income for private practitioners who bill patients on a commercial fee-for-service basis.

In short, the fact that non-profit hospitals promote health care does not automatically qualify them as "charitable." Non-profit hospitals, like other non-profit organizations, are only charitable when they serve the poor, either exclusively or as part of the relevant community.

2. Contrary to the position urged by the defendants and the American Hospital Association (AHA), the generally accepted legal sense of the word "charitable" as applied to hospitals under state case law has been, and continues to be, that hospitals must be open to all, regardless of ability to pay, in order that they be considered "charitable." This basic requirement appears throughout, in the cases which plaintiffs cite in their principal brief (Pl. Br. 29-30), the cases which defendants cite in their brief (Def. Br. 86 n. 51) and the cases which AHA cites in its brief (AHA Br. 25-29).[20] This is not archiac law as suggested by defendants and the AHA. For example, *Burgess* v. *Four States Memorial Hospital*, 250 Ark. 485, 465 S.W. 2d 693 (1971) and *Jackson County* v. *State Tax Commission*, 521 S.W. 2d 378 (Mo. 1975), represent recent, detailed statements that service to rich *and poor* alike is still a requirement for "charitable" hospitals under the laws of those states.

Most of the cases which defendants and AHA cite for the proposition that health is charitable *per se* focus on the question of the hospital's non-profit status, and

[20] The same requirement is contained in the cases which Professor Scott cites in support of the "charitable *per se*" statement which defendants borrowed in Revenue Ruling 69-545. *See also*, Comment, *Hospitals, Tax Exemption and the Poor*, 10 Harv. Civ. Rights-Civ. Lib. L. Rev. 653, 679 (1975).

an examination of the opinions demonstrates that the courts were operating on the assumption that the doors of the hospitals were open to all. *E.g.*, *City of Richmond* v. *Richmond Memorial Hospital*, 202 Va. 86, 116 S.E. 2d 79 (1960). See also opinion in *Jackson County*, *supra*, where the Supreme Court of Missouri noted that, while some Missouri courts had used language which would suggest that health is charitable *per se*, that is not the state of the law in Missouri:

> "Not one of such cases, however, has reached a decision solely within the limitations of such words, and an abbreviated reference to the standard can be found only in those instances where all of the appendages, i.e., *available to all, rich or poor* . . . were not particularly significant or a controlling factor in disposition of the case." (emphasis supplied).

There are a few cases which do not require free care from hospitals as charitable institutions, but a closer examination of most of those cases reveals that the state specifically included non-profit hospitals as a category for tax exempt status by name, e.g., New York (*People ex rel. Doctor's Hospital* v. *Sexton*, 267 App. Div. 736, 48 N.Y.S.2d 201 (1944)). Congress rejected this very same separate categorization as an amendment to sections 501(c)(3) and 170(c) in 1969 (see Pl. Br. 25-28).[21]

[21] Aside from their reliance upon an alleged trend of state case law, defendants assert that Revenue Ruling 69-545 is justified under the general proposition "that the law of charitable trusts has always included a category for purposes beneficial to the community" (Def. Br. 87). Plaintiffs do not take issue with that statement, but note that under the common law, the services of the charitable organization must be available to *all* persons, rich and poor alike, unless the organization comes within one of three specified heads of charity (relief of the poor, education, or religion) and health is not one of these heads. In this respect, the oft-cited common-law definition of Lord McNaughten provides:

> "Charity in its legal sense comprises four principal divisions: trusts for the relief of poverty; trusts for the advancement of

3. Defendants also justify their "modification" of the law on the same basis which they sucessfully urged upon the Court of Appeals, i.e., that the requirement of free care to the indigent "fails to recognize the changing economic, social and technological precepts and values of contemporary society" (Def. Br. 93). However, they totally ignore the fact that Revenue Ruling 69-545 contained no such conclusion.[22] They contend that the Ruling demonstrates a concern with the needs of the poor, by requiring free emergency room care (Def. Br. 89), but proffer no empirical evidence to demonstrate the basis upon which the Internal Revenue Service, which lacks expertise in health affairs, could come to a conclusion that the poor no longer need free inpatient care.[23]

4. Defendants also take the position that the indigent care requirement of Revenue Ruling 56-185 is adminis-

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education; trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the preceding heads. The trusts last referred to are not the less charitable in the eye of the law, because incidentally they benefit the rich as well as the poor, as indeed, every charity that deserves the name must do either directly or indirectly." *Commissioners for Special Purpose of Income Tax* v. *Pemsel* (1891) A.C. 531, 583.

[22] The elimination of the free care requirement in Revenue Ruling 69-545 was predicated solely upon the law of charitable trusts (itself erroneously stated—pp. 16-17 *supra*). Defendants do not respond to the admonition in decisions of this Court that an appellate court cannot substitute its own determination of policy, or the *post hoc* rationalization of appellate counsel, for the grounds relied upon by the administrative agency (Pl. Br. 30-31).

[23] Plaintiffs have demonstrated in their principal brief that the health system and health policy of this country still requires free inpatient care to the indigent in non-profit hospitals (Pl. Br. 31-37). They have been supported in this position by the *amicus* briefs of the American Public Health Association (APHA Br. 14-30) and Jackson County, Missouri (Jackson Br. 10-15). Defendants have totally failed to respond to the serious questions raised in all three briefs, that Revenue Ruling 69-545 has deprived millions of poor people, without any public or private health insurance, of access to inpatient hospital services.

tratively unworkable (Def. Br. 95). They argue that even a hospital with available surplus funds may need to modernize facilities or install new equipment and that the IRS cannot determine how much should be spent for these purposes rather than for free care. But in many other contexts defendants develop guidelines for assuring compliance with the law;[24] they can do so here. Moreover, they can make use of HEW's Hill-Burton regulations which also require hospitals to provide a reasonable volume of free care.[25]

The crucial point, as Revenue Ruling 56-185 recognized, is that a hospital may not modernize facilities and install new equipment solely for the benefit of those who can afford to pay.[26] A hospital that devotes all its re-

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[24] *See, e.g.*, Rev. Proc. 74-26, 1974-2 Cum. Bull. 478; Rev. Proc. 66-34, 1966-2 Cum. Bull. 1232; 26 CFR § 1.170A-9(e)(2); 26 CFR § 1.305-5(b)(2) which provide percentage guidelines to assure compliance with regulatory terms such as "substantially all," "substantial" and "reasonable." See also, 40 Fed. Reg. 53409, Nov. 18, 1975, in which IRS sets forth detailed guidelines to determine for purposes of section 501(c)(3) whether private schools have racially nondiscriminatory policies as to students.

[25] The Hill-Burton regulations require hospitals to provide free care equal to 10 per cent of their Hill-Burton grant or 3 per cent of cost of operations, or else certify that they turn no one away from inpatient and outpatient care. 42 C.F.R. 53.111(d). Similarly, the IRS could establish a guideline based on the percentage of the charitable contributions received by a hospital or its income, or else require that the hospital turn no one away.

In the context of §§ 501(c)(3) and 170(a)-(c), the financial ability of a hospital to provide free care is probably best measured in terms of the charitable contributions it receives. A hospital cannot argue that it is unfair to require it to spend a percentage, *e.g.*, 50 per cent, of the charitable contributions it receives to provide charitable services to the poor. If charitable contributions are used only to provide services to those who can afford to pay, there is, as *Amicus* Jackson County puts it, "a windfall to the affluent" (Jackson Br. 16).

[26] As noted above (p. 13, *supra*), Revenue Ruling 56-185 stated that a hospital could set aside earnings for improvements and additions provided that it "must not, however, refuse to accept patients in need of hospital care who cannot pay for such services."

sources to benefit persons who can pay for care is not providing charitable service and is not entitled to a § 501(c)(3) exemption.

IV. IRS PROMULGATION OF REVENUE RULING 69-545 VIOLATED THE RULEMAKING REQUIREMENTS OF SECTION 553 OF THE ADMINISTRATIVE PROCEDURE ACT.

Section 553 of the APA requires an agency to afford public notice and an opportunity for comment when the agency engages in substantive rulemaking. Defendants argue that Revenue Ruling 69-545 is an interpretative rule and, therefore, exempt from APA requirements (Def. Br. p. 97). Plaintiffs' principal brief showed that under the functional test courts apply to determine whether a rule is substantive or interpretative, this Ruling is substantive and thus subject to section 553 (Pl. Br. 42-49).

A functional test has the advantage of avoiding the semantic difficulties with which courts and commentators have long wrestled.[27] However, even relying on the definitional approach the defendants opt for, and recognizing further that, because of the impreciseness of the definitions, there is a substantial fringe area in which the distinction between substantive and interpretative rulings is blurred, Revenue Ruling 69-545 must be categorized as substantive.

Defendants take their definitions of "substantive" and "interpretative" from *Gibson Wine Co.* v. *Snyder*, 194 F.2d 329, 331 (D.C.Cir. 1952). There, the Court of Appeals for the District of Columbia Circuit stated that a substantive rule is one which "creates law" implementary to existing law while an interpretative rule is one in which an administrator announces an official agency position on the meaning of a particular term as used in a statute. These definitions parallel closely those offered by Congress when it created the exemption from section 553 for interpretative rules. The legislative history refers to a substantive ruling as a ruling which serves a statutory role because it involves subject matter demanding judgments based on technical knowledge and experience; it refers to an interpretative rule as an administrative construction of a statutory provision.[28]

The definitions from *Gibson Wine Co.* and from the legislative history carry the same import. An administrative interpretation is an agency decision as to what the agency thinks Congress meant when it enacted a statute. On the other hand, substantive rules address the problems and practicalities of implementing a statutory scheme. They provide the detail about how a program will work that Congress would provide if it had the time, organization and staff to do so. Substantive rules involve factual and value judgments to which agency expertise can make a substantial contribution. Comments from outsiders as mandated by section 553 help to ensure that all relevant information reaches the agency.

Defendants argue that the difference between the two types of rulings is that an interpretative ruling is not legally binding. The use of the term "legally binding" in this context is misleading. When used to refer to administrative rulings, it simply designates the standard for judicial review. Substantive rulings, because they involve agency expertise and require a comment period under section 553, are reviewed only for arbitrariness and are said to be "legally binding." Interpretative rulings are subject to plenary review and therefore are

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[27] *See, e.g., National Motor Freight Traffic Association, Inc.* v. *United States*, 268 F.Supp. 90, 96 (D.D.C. 1967); *Oil Shale Corp.* v. *Morton*, 370 F.Supp. 108, 121-22 (D. Colo. 1973); K. Davis, 1 Administrative Law Treatise, § 5.09 (1959).

[28] APA Legislative History, 79th Cong. (1944-46) at 408.

not "legally binding" because a court is as capable as an agency of defining statutory language on the basis of legislative history and purpose. See *Davis, supra*, § 5.03.[29]

In the case of Revenue Ruling 69-545 defendants cannot pretend that they are only divining what Congress meant when it first included the word "charitable" in the exemption provision of the Internal Revenue Code in 1894.[30] Instead, defendants are responding to what they view as changes in the needs of the poor for health care services. The statute and the legislative history (both of the original act and later amendments) could not adequately guide the IRS in addressing the changed economic, social and political situations which motivated IRS to revise its standards governing charitable hospitals. The ruling embodies complex judgments, not mere statutory construction, and thus is clearly substantive. Those who will be affected by any changes IRS makes can offer IRS insight into what the competing interests are and how they can be reconciled. IRS should and, pursuant to section 553 of the APA, must offer them the opportunity to participate.

Plaintiffs stress that to comply with the APA, IRS must simply publish a notice of proposed rulemaking in the *Federal Register* and allow a period for public comment. This is not an unreasonable burden to impose on the IRS.[31] In the usual case, comments will be

[29] Whether or not a ruling is legally binding does not affect the conduct of a party, except perhaps psychologically. If an individual believes it is invalid, he may just as easily violate a substantive ruling or even a statute, as an interpretative ruling. In all cases, compliance must be sought either in an administrative proceeding or in court.

[30] Act of August 15, 1894, ch. 349, 28 Stat. 553.

[31] Contrary to the intimation of defendants, compliance with the APA does not threaten the current program of IRS letter rulings. Letter rulings are IRS opinions concerning the federal tax consequences of *specific* proposed transactions. The legislative history makes it clear that advisory rulings in particular cases, such as

few and IRS will be the preeminent expert. In the rare instances in which IRS proposals generate numerous responses because of the importance or controversiality of the issues, it is proper that affected persons have an input.

CONCLUSION

For the foregoing reasons the judgment of the United States Court of Appeals for the District of Columbia Circuit should be reversed and the case remanded.

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letter rulings, are not covered by section 553 of the APA. APA Legislative History, 79th Cong. (1944-46) at 355.

* Counsel gratefully acknowledge the assistance of Mary Anne Sullivan, law student intern at the Center for Law and Social Policy.

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